University Hospital Crosshouse
Legal Desk
Health Records
Kilmarnock Road
Kilmarnock
KA2 0BE

NHS Ayrshire & Arran

MMA Legal
43-59 Princes Street
Stockport
SK1 1RY

Date 30th June 2026
Our Ref JG/1406650854
Your Ref 100051
Enquires to Jenny
Telephone 01563 827076
E-mail SubjectAccessRequest@aapct.scot.nhs.uk

Dear Sir/Madam

GENERAL DATA PROTECTION REGULATION (GDPR) SUBJECT ACCESS REQUEST
RE: Stephen Galloway, 28 Redburn Place, Irvine

I refer to your recent letter requesting access to your client's Medical Records under the above Act.

I have now had the approval of the relevant Clinicians to provide you with a copy of the notes and enclose herewith the relevant documents.

I would be grateful if you could email the above address or return the tear-off slip to confirm safe receipt of the documents.

Yours faithfully,

pp JHall

Mr R H Bryden
Head of Health records Services

Please return to: **University Hospital Crosshouse, Legal Desk, Health Records, Kilmarnock Road, Kilmarnock KA2 0BE.**

I acknowledge receipt of the copies of medical records pertaining to:

Stephen Galloway, CHI: 1406650854

Symphony A&E records
Electronic patient records
Ayr Hospital records
Crosshouse Hospital records

Signed: ---------- Date: ----------

Designation: ----------

30/06/2026 00:00 < Attendance Date > 30/06/2026 11:59

Name	Date Of Birth	Arrival Date	Att Number	Presenting Complaint	Left Dept Date
Galloway, Stephen ()	14/06/1965	11/04/2026 15:20	XH-26-017318-1	intoxicated?	11/04/2026 16:51
Galloway, Stephen ()	14/06/1965	10/12/2024 19:18	XH-24-058652-1	Head Inj intoxicated	10/12/2024 23:46
Galloway, Stephen ()	14/06/1965	31/10/2024 00:50	XH-24-051919-1	intoxicated fall	31/10/2024 01:23
Galloway, Stephen ()	14/06/1965	10/06/2024 23:10	XH-24-028073-1	sob amb	11/06/2024 11:36
Galloway, Stephen ()	14/06/1965	12/10/2023 22:21	XH-23-047519-1	chest pain	14/10/2023 11:44
Galloway, Stephen ()	14/06/1965	09/10/2023 00:02	XH-23-046821-1	chest pain	09/10/2023 00:44
Galloway, Stephen ()	14/06/1965	06/10/2021 08:10	XH-21-046058-1	DIB	06/10/2021 09:39
Galloway, Stephen ()	14/06/1965	12/12/2020 23:18	XH-20-055125-1	unwell	13/12/2020 09:12
Galloway, Stephen ()	14/06/1965	31/08/2020 22:53	XH-20-039960-1	unwell adult	31/08/2020 23:06
Galloway, Stephen ()	14/06/1965	11/06/2020 23:07	XH-20-025487-1	intoxicated	12/06/2020 02:54
Galloway, Stephen ()	14/06/1965	09/04/2019 20:28	XH-19-019704-1	chest pain	09/04/2019 23:10
Galloway, Stephen ()	14/06/1965	04/11/2018 10:45	XH-18-059611-1	high blood pressure	04/11/2018 10:51
Galloway, Stephen ()	14/06/1965	26/08/2018 03:20	XH-18-045595-1	pain in side	26/08/2018 04:31
Galloway, Stephen ()	14/06/1965	07/09/2017 07:44	XH-17-047061-1	fall	07/09/2017 08:39
Galloway, Stephen ()	14/06/1965	27/06/2017 13:35	XH-17-033783-1	fall head inj	27/06/2017 14:43
Galloway, Stephen ()	14/06/1965	24/08/2016 12:12	XH-16-048324-1	chest pain	24/08/2016 15:48
Galloway, Stephen ()	14/06/1965	21/01/2015 17:38	XH-15-004043-1	unwell man	21/01/2015 19:00
Galloway, Stephen ()	14/06/1965	10/06/2002 14:35	XH-02-023925-1	INJ R BIG TOE	10/06/2002 15:10
Galloway, Stephen ()	14/06/1965	15/05/2002 06:23	XH-02-019871-1	Assault	15/05/2002 08:01
Galloway, Stephen ()	14/06/1965	12/05/2002 12:24	XH-02-019428-1	Limb Injuries	12/05/2002 14:30
Galloway, Stephen ()	14/06/1965	12/10/2001 18:21	XH-01-042088-1	Wounds	12/10/2001 19:30
Galloway, Stephen ()	14/06/1965	11/10/2001 18:15	XH-01-041937-1	LAC R FOREARM	11/10/2001 19:34
Galloway, Stephen ()	14/06/1965	21/07/2001 19:51	XH-01-029767-1	OD + poisoning	21/07/2001 20:27
Galloway, Stephen ()	14/06/1965	09/12/2000 09:45	XH-00-050169-1	Assault	09/12/2000 11:08
Galloway, Stephen ()	14/06/1965	10/10/1999 21:08	XH-99-040936-1	VOMITING BLOOD	10/10/1999 22:16

Discharge Outcome	Discharged To	CHI Number
Patient left before assessment completed	Usual place of residence	1406650854
Discharge, no follow up	Usual place of residence	1406650854
Not Known	Not Known	1406650854
Admitted		1406650854
Admitted		1406650854
Patient left before assessment completed	Usual place of residence	1406650854
Discharge, no follow up	Usual place of residence	1406650854
Admitted		1406650854
Not Known	Not Known	1406650854
Discharge, no follow up	Usual place of residence	1406650854
Discharge, no follow up	Usual place of residence	1406650854
Discharge, opt in letter to Physio	Usual place of residence	1406650854
Discharge, no follow up	Police	1406650854
Discharge, no follow up	Usual place of residence	1406650854
Discharge, no follow up	Usual place of residence	1406650854
Admitted		1406650854
Admitted		1406650854
Discharge, no follow up		1406650854
ED Clinic		1406650854
Admitted		1406650854
GP		1406650854
GP		1406650854
Admitted		1406650854
Other Clinic		1406650854
Admitted		1406650854

Care Partner

Galloway, Stephen (Mr)

Date of Birth 14-Jun-1965 (60y) undefined Male CHI Number 1406650854

History for Summary of contact/details

From Invalid dateCentre of Care Primary Care MH - North

Assessed 24th Jan 2013 at 10:17

Summary of contact/details	

Dear Dr Perman

Re: STEPHEN GALLOWAY 66 GARNOCK STREET DALRY KA24 4AW

Further to your referral of the above-named, this patient has been offered the opportunity to contact us to make an appointment for an assessment.

Unfortunately, as the patient has failed to make contact with the Department, I can only assume that he does not wish to pursue assessment with our service at this time. I have, therefore, no option but to discharge him from our service.

Please do not hesitate to re-refer this patient should he show a commitment to attend.

Assessed 9th Jan 2013 at 11:01

Summary of contact/details	

Dear Mr Galloway

You have been referred to the North Ayrshire Primary Care Mental Health Team by Dr Perman.

To arrange an appointment please telephone 01294 323216 or 01294 322044.

Your first appointment will be a brief meeting to tell you more about the type of interventions the team provides and find out more about your problems. The nurse may provide you with information and contacts for other organisations/services that you will find useful.

Following your first appointment if our service can help you with your problems you will go on a waiting list. The nurse that you meet with will be able to give you further information on how long you will have to wait for treatment and your GP will be informed of the outcome of the appointment.

If you do not contact the Primary Care Mental Health Team by 23rd January 2013 we will assume that you no longer require to be seen and your GP will be informed that you have been discharged from our service. Please see enclosed leaflet for important information.

Thank you for your co operation.

Assessed 9th Jan 2013 at 10:58

Summary of contact/details	
-	

Assessed 14th Mar 2012 at 11:47

Summary of contact/details	

Care Partner

Galloway, Stephen (Mr)

Date of Birth 14-Jun-1965 (60y) undefined Male CHI Number 1406650854

History for Summary of contact/details

From Invalid dateCentre of Care Primary Care MH - North

-Mr Galloway did not attend his arranged appointment and has made no contact with the NAPCMHT for more than 7 days. He has been discharged from the authors' caseload as per the NAPCMHT discharge policy and is now returned to the ongoing care of his GP.

Assessed 6th Mar 2012 at 14:30

Summary of contact/details	
-Mr Galloway did not attend his arranged appointment and has made no contact with the NAPCMHT. If he makes no contact within the next seven days he will be discharged from the authors' caseload as per the NAPCMHT discharge policy and will be returned to the ongoing care of his GP.	

Assessed 10th Feb 2012 at 12:19

Summary of contact/details	
Dear Mr Galloway Thank you for your telephone call to my office cancelling our appointment. I am able to offer you another appointment on:- Date:- Tuesday, 21st February, 2012 Time:- 2.30 p.m. Location:- Outpatient Department, Ayrshire Central Hospital I trust this is suitable. If not, please contact my secretary at the above number in advance. Please note that due to the demand for our service it is our policy to discharge patients who fail to attend or cancel two consecutive appointments back to the care of their General Practitioner.	

Assessed 10th Feb 2012 at 10:23

Summary of contact/details	
-Mr Galloway phoned and spoke to the writer to cancel his appointment citing ill physical health. He requested another appointment which will be sent by post.	

Assessed 24th Jan 2012 at 14:18

Summary of contact/details	
Dear Mr Galloway Thank you for your telephone call to my office on 24th January, 2012 cancelling our appointment. I am able to offer you another appointment on:- Date:- Tuesday, 7th February, 2012 Time:- 2.00 p.m.	

Care Partner

Galloway, Stephen (Mr)

Date of Birth 14-Jun-1965 (60y) undefined Male CHI Number 1406650854

History for Summary of contact/details

From Invalid dateCentre of Care Primary Care MH - North

Location:- Outpatient Department, Ayrshire Central Hospital

I trust this is suitable. If not, please contact my secretary at the above number in advance

Assessed 24th Jan 2012 at 13:05

Summary of contact/details	
-Mr Galloway phoned and spoke with admin staff to cancel his appointment due to being "unwell" and requested another.	

Assessed 13th Jan 2012 at 14:33

ummary of contact/details	

Dear Mr Galloway

Further to your recent screening appointment, I am writing to offer you an appointment to commence treatment with Gavin Thompson, Primary Care Mental Health Nurse

On: Tuesday, 24th January, 2012

At: 3.00 p.m.

Location: Outpatient Department, Ayrshire Central Hospital

If you no longer feel you need an appointment, please could you let us know.

I am enclosing two questionnaires (GAD-7, PHQ-9), which we would be grateful if you could complete and bring with you to the appointment - it is especially important that the questionnaires are completed reflecting how you felt the week before your appointment. Please be assured that you are welcome to attend the service whether or not you complete the forms.

If we do not hear from you or you fail to attend your appointment we shall assume you wish no further appointments at this time and will discharge you back to the care of your GP.

Assessed 14th Dec 2011 at 15:11

Summary of contact/details	

Care Partner

Galloway, Stephen (Mr)

Date of Birth 14-Jun-1965 (60y) **undefined** Male **CHI Number** 1406650854

History for Summary of contact/details

From Invalid date**Centre of Care** Primary Care MH - North

Mr Galloway attended Brief screening Appointment today on referral from GP. Details of referral relayed and greed to be correct although stating the problems within his relationship began prior to allegations against his partners son.

Presented tearful and anxious throughout contact, reporting occasional suicidal ideation with some preparatory act of fixing a noose to his loft rafters. States thoughts of impact on his children prevents him acting on same recognises this is not the answer for him. Reports persistent negative thoughts about his ability to cope with going through court proceedings to get access to his two children. Describes reduced motivation and energy with poor sleep and lowered appetite. Also admitting to feelings of anger towards his ex partner and frustration at his perceived lack of support.

Mr Galloway had no clear idea of what he would like help with and his only desire is to get his children back. Advised this is not omething PCMHT could help him with and he is already attending lawyers in connection with getting access/custody. Advised him that service could help him with symptom management and he agreed to attending sessions with this aim. Writer advised on time limits and expectations with regard attendance and commitment to engage to which he agreed. Placed name on Nursing Waiting list, Mr Galloway agreeing to be seen anywhere and at anytime.

Assessed 15th Nov 2011 at 11:34

Summary of contact/details	

Dear Mr Galloway

You have been referred to the North Ayrshire Primary Care Mental Health Team by Dr Perman.

To arrange an appointment please telephone 01294 323216 or 01294 322044.

Your first appointment will be a brief meeting to tell you more about the type of interventions the team provides and find out more about your problems. The nurse may provide you with information and contacts for other organisations/services that you will find useful.

ollowing your first appointment if our service can help you with your problems you will go on a waiting list. The nurse that you meet with will be able to give you further information on how long you will have to wait for treatment and your GP will be informed of the outcome of the appointment.

If you do not contact the Primary Care Mental Health Team by 29th November 2011 we will assume that you no longer require to be seen and your GP will be informed that you have been discharged from our service. Please see enclosed leaflet for important information.

Thank you for your co operation.

Assessed 15th Nov 2011 at 10:00

Summary of contact/details	
-	

Care Partner

Galloway, Stephen (Mr)

Date of Birth 14-Jun-1965 (60y) undefined Male CHI Number 1406650854

History for Summary of contact

Centre of Care North Drug & Alcohol Rec Serv

Assessed 18th Mar 2019 at 15:23

Summary of contact	
Addictions V3 Activity Record dated 18/3/19 clinically emailed to GP 19/3/19	

Assessed 18th Mar 2019 at 15:03

Summary of contact/details	
Stephen failed to attend for assessment with writer at Boutreehill health centre as arranged via letter. Stephen will be discharged with GP being notified of contact.	

Assessed 3rd Jan 2019 at 11:40

Summary of contact	
Activity Record RE Discharge sent to Frew Terrace Surgery on 18/01/19.	

Assessed 3rd Jan 2019 at 10:14

Summary of contact/details	
To whom it may concern , Steven was referred by his GP for alcohol assessment and was appointed and assessed on the 20/11/2018. At this time Stephen reported that he had stopped drinking after a medical detox in Crosshouse hospital. Stephen was further appointed for a follow up on the 05/12/2018 and did not attend this. A 7 day letter was sent out. As no communication has been had from Stephen at this time he will be discharged from the service. Stephen can self refer if he wishes an intervention from the service in the future. Please do not hesitate to contact me if further information is required. Yours sincerely Sheena Orr Staff Nurse RMN North Ayrshire Drug and Alcohol Recovery Service (NADARS) North Ayrshire Health and Social Care Partnership Caley Court Resource Centre Moorpark Road West Stevenston KA20 3HU Tel: 01294 476000	

Assessed 5th Dec 2018 at 09:49

Summary of contact/details	
Stephen did not attend for his appointment at Caley Court this morning at 9.30am. No contact has been made at this time. Stephen will be sent a 7 day letter, and if no communication is had by 14/12/2018 Stephen will be discharged from the service.	

Care Partner

Galloway, Stephen (Mr)

Date of Birth 14-Jun-1965 (60y) undefined Male CHI Number 1406650854

History for Summary of contact

Centre of Care North Drug & Alcohol Rec Serv

Assessed 20th Nov 2018 at 14:02

Summary of contact/details	
Stephen was referred by his GP for alcohol assessment on the 02/11/2018, Stephen was appointed and assessed today at Caley Court at 10.30am. Stephen was admitted to Crosshouse Hospital on the 07/11/2018 for high blood pressure and was detoxed from alcohol at this time. Stephen reports that he has had no alcohol since discharge 10/11 days and intends to remain abstinent. Stephen states that his main problem is boredom. Plan: Stephen to remain abstinent from alcohol. Stephen will attend his health appointments 26/11/2018 and await results re his liver function and update writer on same for suitability of Acamprosate medication. Stephen to attend court on Tuesday 27/11/2018 for domestic abuse charge and update writer Stephen denied referral to ward 5 and relapse prevention group as he states he will be working over the next couple of weeks to get money for Christmas but will consider them in the New Year. Stephen aware of the numbers to contact if he feels he needs further support in the meantime. Please see Generic ICP dated 20/11/2018 for further information .	

Assessed 8th Nov 2018 at 10:40

Summary of contact	
Current Hospital Crosshouse Hospital Current Speciality Acute Medicine Admitting Ward CAU XH Pre Arrival Waiting Area Current Ward CAU XH Rapid Assessment CHI 1406650854 Admission Date 04/11/2018 Admission Time 10:52:00 Discharge Date 07/11/2018 Discharge Time 13:07:00 Discharge Destination Private Residence - living alone	

Care Partner

Galloway, Stephen (Mr)

Date of Birth 14-Jun-1965 (60y) undefined Male CHI Number 1406650854

History for Summary of contact

Until 05/05/2026

Assessed 17th Dec 2020 at 12:31

Summary of contact	

Situation
Electronic referral received from Ambulatory Care, Crosshouse Hospital. Stephen admitted to general hospital with visual and auditory hallucinations related to alcohol withdrawals. States he stopped drinking abruptly on the Tuesday and by the Friday was feeling unwell with hallucinations. Stephen advised he was drinking 2 litres of Morgans daily for 12 days. Attempted face to face assessment yesterday, however no private space available. Alcohol information pack provided

ackground
revious assessments via alcohol liaison. Brief input via NADARS, however Stephen did not find this helpful.

Stephen lives with his 17 year old daughter. States he is appealing a recent PIP application with assistance from Money Matters. He struggles financially at times as he has to look after his daughter also, however is managing at present. He enjoys walking his dog and is able to keep himself occupied.

Stephen states he drinks to excess for a few weeks at a time and usually reduces slowly when he decides to stop. States he was feeling unwell and stopped too quickly.

Assessment
Telephone assessment. Rapport was easily established. Speech was normal in rate, volume and intonation. Subjectively and objectively mood euthymic with reactive affect. Appetite and sleep pattern both good. No evidence of anxiety/distress. No evidence of psychotic symptomatology. No evidence of suicidal ideation, plan or intent. Clear evidence of future planning and daughter a protective factor.

Stephen had not read through alcohol information pack yet, however is planning too. Advised of Turning Point for support to remain abstinent, however Stephen appeared reluctant. Advised he can self refer if he changes his mind

Recommendations
Stephen will consider self referral to Turning Point and have a read through alcohol information pack
Aware of the risks of stopping drinking abruptly
Discharged from ALN point of view

Assessed 16th Dec 2020 at 14:48

Summary of contact/details	

Attended Ambulatory Care today for alcohol liaison assessment. There was no private space available for assessment. Spoke briefly with Stephen at his bedside. Agreed ALN will provide telephone consultation once home and Stephen happy with same. Alcohol information pack provided.

Assessed 14th Dec 2020 at 14:15

Summary of contact/details	

Referral received from CAU staff requesting input from ALN, writer contacted ward, spoke to named nurse who advised that Stephen is not medically fit for discharge home today, advised Stephen receiving treatment re: adverse alcohol withdrawals - advised same being managed by ward medic, confirmed that Stephen on GMAWS and Parbrinex, advised EDD as 17/12/20, writer accepting of same and advised that ALN will contact ward 17/12/20 for update and if Stephen medically fit to be discharged home then ALN will attend ward, advised if any sooner concerns/advise required to contact liaison via switch, nurse happy with same.

Care Partner

Galloway, Stephen (Mr)

Date of Birth 14-Jun-1965 (60y) undefined Male CHI Number 1406650854

History for Summary of contact

Until 05/05/2026

Assessed 10th Apr 2019 at 14:01

Summary of contact	
ARAF dated 10th April 2019 sent to A & E and GP	

Assessed 10th Apr 2019 at 11:24

Summary of contact	
Referred to NADARS Alcohol information pack posted out. Discharged from the ALS.	

Assessed 18th Mar 2019 at 15:23

Summary of contact	
Addictions V3 Activity Record dated 18/3/19 clinically emailed to GP 19/3/19	

Assessed 18th Mar 2019 at 15:03

Summary of contact/details	
Stephen failed to attend for assessment with writer at Boutreehill health centre as arranged via letter. Stephen will be discharged with GP being notified of contact.	

Assessed 3rd Jan 2019 at 11:40

Summary of contact	
Activity Record RE Discharge sent to Frew Terrace Surgery on 18/01/19.	

Assessed 3rd Jan 2019 at 10:14

Summary of contact/details	
To whom it may concern , Steven was referred by his GP for alcohol assessment and was appointed and assessed on the 20/11/2018. At this time Stephen reported that he had stopped drinking after a medical detox in Crosshouse hospital. Stephen was further appointed for a follow up on the 05/12/2018 and did not attend this. A 7 day letter was sent out. As no communication has been had from Stephen at this time he will be discharged from the service. Stephen can self refer if he wishes an intervention from the service in the future. Please do not hesitate to contact me if further information is required. Yours sincerely Sheena Orr Staff Nurse RMN North Ayrshire Drug and Alcohol Recovery Service (NADARS)	

Care Partner

Galloway, Stephen (Mr)

Date of Birth 14-Jun-1965 (60y) undefined Male CHI Number 1406650854

History for Summary of contact

Until 05/05/2026

North Ayrshire Health and Social Care Partnership
Caley Court Resource Centre
Moorpark Road West
Stevenston KA20 3HU
Tel: 01294 476000

Assessed 5th Dec 2018 at 09:49

Summary of contact/details	

Stephen did not attend for his appointment at Caley Court this morning at 9.30am. No contact has been made at this time.
tephen will be sent a 7 day letter, and if no communication is had by 14/12/2018 Stephen will be discharged from the service.

Assessed 20th Nov 2018 at 14:02

Summary of contact/details	

Stephen was referred by his GP for alcohol assessment on the 02/11/2018, Stephen was appointed and assessed today at Caley Court at 10.30am.
Stephen was admitted to Crosshouse Hospital on the 07/11/2018 for high blood pressure and was detoxed from alcohol at this time. Stephen reports that he has had no alcohol since discharge 10/11 days and intends to remain abstinent. Stephen states that his main problem is boredom.
Plan:
Stephen to remain abstinent from alcohol.
Stephen will attend his health appointments 26/11/2018 and await results re his liver function and update writer on same for suitability of Acamprosate medication.
Stephen to attend court on Tuesday 27/11/2018 for domestic abuse charge and update writer
Stephen denied referral to ward 5 and relapse prevention group as he states he will be working over the next couple of weeks to get money for Christmas but will consider them in the New Year.
tephen aware of the numbers to contact if he feels he needs further support in the meantime.
lease see Generic ICP dated 20/11/2018 for further information .

Assessed 9th Nov 2018 at 14:04

Summary of contact	

Dear Dr Manuel

RE: STEPHEN GALLOWAY DOB: 14/06/1965 CHI: 1406650854

The above named patient was referred to the Alcohol Liaison Service during his recent admission to Crosshouse Hospital.

I have enclosed, for your information, an Activity Record and please do not hesitate to contact me should you wish to discuss this further.

Yours sincerely
Margaret Frew
Alcohol Liaison Nurse

Galloway, Stephen (Mr)

Date of Birth 14-Jun-1965 (60y) undefined Male CHI Number 1406650854

History for Summary of contact

Until 05/05/2026

Enc

cc Dr Miller, Frew Terrace Surgery, Irvine.

Assessed 9th Nov 2018 at 11:32

Summary of contact	

PLAN OF CARE AS DISCUSSED AND AGREED WITH STEPHEN

ABI completed. ALN will send Stephen out an alcohol information pack and will refer him to NADARS for support to maintain bstinence from alcohol; 1:1 psychosocial support and for assessment for the rehab programme at ward 5. Stephen was rientated to time, place and person with no evidence of any decision impairing condition. He reported his mood is a low and self rated it at 2/10 on a scale of 1-10; 10 being good. He reported previous suicidal thoughts but nil currently.

Stephen is keen for information on Disulfiram and Acamprosate which the ALN will send to him. He can then discuss this medication with his GP.

Discharged from the ALS.

Assessed 8th Nov 2018 at 10:40

Summary of contact	

Current Hospital Crosshouse Hospital
Current Speciality Acute Medicine
Admitting Ward CAU XH Pre Arrival Waiting Area
Current Ward CAU XH Rapid Assessment
CHI 1406650854
dmission Date 04/11/2018
dmission Time 10:52:00
Discharge Date 07/11/2018
Discharge Time 13:07:00
Discharge Destination Private Residence - living alone

Assessed 8th Nov 2018 at 09:48

Summary of contact/details	

Phone call to Stephen's mobile. Went direct to voicemail. Short message left to advise I will call back later.

Assessed 7th Nov 2018 at 17:23

Summary of contact/details	

Telephone call from Initial assessment Unit XH hospital to refer Stephen whom they advised is medically fit and scheduled for discharge home today. ALN unable to see Stephen for assessment today but willing to offer a telephone consultation. Discussed with nurse Katie Fairlie who spoke with Stephen and advised he is agreeable to a telephone consultation.

Admitted to XH hospital 04/11/2018.
Discharged 07/11/2018.
OP appointment on 09/11/2018.

Care Partner

Galloway, Stephen (Mr)

Date of Birth 14-Jun-1965 (60y) undefined Male CHI Number 1406650854

History for Summary of contact

Until 05/05/2026

ALN contacted Stephen by phone at 17:00hrs on 07/11/2018. Stephen advised he had been admitted to hospital with abdominal pain and HTN. States he had been drinking 1-1 1/2 litres of spirits daily until the day prior to his admission to hospital. States he had been having a detox from alcohol during his admission but has no detox medication currently and has tremors. Stephen advised he has had previous DTs and previous alcohol withdrawal seizures. The ALN suggested Stephen monitors symptoms of withdrawal from alcohol and if they worsen he should either seek medical help or drink alcohol. Advised he can contact NHS 24 for advice out of hours. We agreed the ALN will phone Stephen tomorrow 08/11/2018 to inquire how he is and what actions he may have taken overnight. The ALN will then refer Stephen to NADARS or another local alcohol support service as indicated.

Assessed 7th Nov 2018 at 14:00

ummary of contact/details	

ALN paged by XH hospital rapid assessment unit who advised that Stephen is medically fit for discharge and they are seeking ALN assessment asap. ALN unable to schedule in today but did offer a telephone consultation which has been accepted and will follow later today or tomorrow.

Assessed 24th Jan 2013 at 10:17

Summary of contact/details	

Dear Dr Perman

Re: STEPHEN GALLOWAY 66 GARNOCK STREET DALRY KA24 4AW

Further to your referral of the above-named, this patient has been offered the opportunity to contact us to make an appointment for an assessment.

Unfortunately, as the patient has failed to make contact with the Department, I can only assume that he does not wish to pursue assessment with our service at this time. I have, therefore, no option but to discharge him from our service.

Please do not hesitate to re-refer this patient should he show a commitment to attend.

Assessed 9th Jan 2013 at 11:01

Summary of contact/details	

Dear Mr Galloway

You have been referred to the North Ayrshire Primary Care Mental Health Team by Dr Perman.

To arrange an appointment please telephone 01294 323216 or 01294 322044.

Your first appointment will be a brief meeting to tell you more about the type of interventions the team provides and find out more about your problems. The nurse may provide you with information and contacts for other organisations/services that you will find useful.

Following your first appointment if our service can help you with your problems you will go on a waiting list. The nurse that you meet with will be able to give you further information on how long you will have to wait for treatment and your GP will be informed of the outcome of the appointment.

If you do not contact the Primary Care Mental Health Team by 23rd January 2013 we will assume that you no longer require to be

Care Partner

Galloway, Stephen (Mr)

Date of Birth 14-Jun-1965 (60y) undefined Male CHI Number 1406650854

History for Summary of contact

Until 05/05/2026

seen and your GP will be informed that you have been discharged from our service. Please see enclosed leaflet for important information.

Thank you for your co operation.

Assessed 9th Jan 2013 at 10:58

Summary of contact/details	
-	

ıssessed 14th Mar 2012 at 11:47

Summary of contact/details	
-Mr Galloway did not attend his arranged appointment and has made no contact with the NAPCMHT for more than 7 days. He has been discharged from the authors' caseload as per the NAPCMHT discharge policy and is now returned to the ongoing care of his GP.	

Assessed 6th Mar 2012 at 14:30

Summary of contact/details	
-Mr Galloway did not attend his arranged appointment and has made no contact with the NAPCMHT. If he makes no contact within the next seven days he will be discharged from the authors' caseload as per the NAPCMHT discharge policy and will be returned to the ongoing care of his GP.	

Assessed 10th Feb 2012 at 12:19

Summary of contact/details	
)ear Mr Galloway Thank you for your telephone call to my office cancelling our appointment. I am able to offer you another appointment on:- Date:- Tuesday, 21st February, 2012 Time:- 2.30 p.m. Location:- Outpatient Department, Ayrshire Central Hospital I trust this is suitable. If not, please contact my secretary at the above number in advance. Please note that due to the demand for our service it is our policy to discharge patients who fail to attend or cancel two consecutive appointments back to the care of their General Practitioner.	

Assessed 10th Feb 2012 at 10:23

Summary of contact/details	
-Mr Galloway phoned and spoke to the writer to cancel his appointment citing ill physical health. He requested another appointment which will be sent by post.	

Care Partner

Galloway, Stephen (Mr)

Date of Birth 14-Jun-1965 (60y) undefined Male CHI Number 1406650854

History for Summary of contact

Until 05/05/2026

Assessed 24th Jan 2012 at 14:18

Summary of contact/details	
Dear Mr Galloway Thank you for your telephone call to my office on 24th January, 2012 cancelling our appointment. I am able to offer you another appointment on:- Date:- Tuesday, 7th February, 2012 Time:-. 2.00 p.m. Location:- Outpatient Department, Ayrshire Central Hospital I trust this is suitable. If not, please contact my secretary at the above number in advance	

Assessed 24th Jan 2012 at 13:05

Summary of contact/details	
-Mr Galloway phoned and spoke with admin staff to cancel his appointment due to being "unwell" and requested another.	

Assessed 13th Jan 2012 at 14:33

Summary of contact/details	
Dear Mr Galloway Further to your recent screening appointment, I am writing to offer you an appointment to commence treatment with Gavin Thompson, Primary Care Mental Health Nurse On: Tuesday, 24th January, 2012 At: 3.00 p.m. Location: Outpatient Department, Ayrshire Central Hospital If you no longer feel you need an appointment, please could you let us know. I am enclosing two questionnaires (GAD-7, PHQ-9), which we would be grateful if you could complete and bring with you to the appointment - it is especially important that the questionnaires are completed reflecting how you felt the week before your appointment. Please be assured that you are welcome to attend the service whether or not you complete the forms. If we do not hear from you or you fail to attend your appointment we shall assume you wish no further appointments at this time and will discharge you back to the care of your GP.	

Assessed 14th Dec 2011 at 15:11

Summary of contact/details	

Galloway, Stephen (Mr)

Date of Birth 14-Jun-1965 (60y) undefined Male CHI Number 1406650854

History for Summary of contact

Until 05/05/2026

Mr Galloway attended Brief screening Appointment today on referral from GP. Details of referral relayed and greed to be correct although stating the problems within his relationship began prior to allegations against his partners son.

Presented tearful and anxious throughout contact, reporting occasional suicidal ideation with some preparatory act of fixing a noose to his loft rafters. States thoughts of impact on his children prevents him acting on same recognises this is not the answer for him. Reports persistent negative thoughts about his ability to cope with going through court proceedings to get access to his two children. Describes reduced motivation and energy with poor sleep and lowered appetite. Also admitting to feelings of anger towards his ex partner and frustration at his perceived lack of support.

Mr Galloway had no clear idea of what he would like help with and his only desire is to get his children back. Advised this is not something PCMHT could help him with and he is already attending lawyers in connection with getting access/custody. Advised him that service could help him with symptom management and he agreed to attending sessions with this aim. Writer advised on time limits and expectations with regard attendance and commitment to engage to which he agreed. Placed name on Nursing Waiting list, Mr Galloway agreeing to be seen anywhere and at anytime.

Assessed 15th Nov 2011 at 11:34

Summary of contact/details	

Dear Mr Galloway

You have been referred to the North Ayrshire Primary Care Mental Health Team by Dr Perman.

To arrange an appointment please telephone 01294 323216 or 01294 322044.

Your first appointment will be a brief meeting to tell you more about the type of interventions the team provides and find out more about your problems. The nurse may provide you with information and contacts for other organisations/services that you will find useful.

Following your first appointment if our service can help you with your problems you will go on a waiting list. The nurse that you meet with will be able to give you further information on how long you will have to wait for treatment and your GP will be informed of the outcome of the appointment.

If you do not contact the Primary Care Mental Health Team by 29th November 2011 we will assume that you no longer require to be seen and your GP will be informed that you have been discharged from our service. Please see enclosed leaflet for important information.

Thank you for your co operation.

Assessed 15th Nov 2011 at 10:00

Summary of contact/details	
-	

Confidential - Clinical Information

Department of Urology
University Hospital Ayr
Dalmellington Road
Ayr
KA6 6DX
01292 610555

www.nhsayrshireandarran.com

NHS Ayrshire & Arran
STA 0616

Dr JA Taylor
Dalry Medical Practice
Dalry Health Centre
50 Vennel Street
Dalry
KA24 4AF

Our Ref:	DR/LP
Hospital No:	
Clinic Date:	02/11/2012
Date Dictated:	02/11/2012
Date Typed:	06/12/2012
Enquiries to	Maureen McCreadie
Direct Line:	
Ext. Number:	14305
Email:	maureen.mccreadie@aaaht.scot.nhs.uk

Dear Dr Taylor,

STEPHEN GALLOWAY DOB: 14/06/1965 CHI No: 140 665 0854
66 GARNOCK STREET, DALRY, AYRSHIRE, KA24 4AW

Mr Galloway has not contacted me since he failed to attend my Clinic in July.

I assume that he is continuing to respond well to Tadalafil.

I plan no further follow up for him although he has my contact number should he need advice.

Yours sincerely

Authorised on 12/12/2012 11:23:31 by Derek Rutherford.

Derek Rutherford
Consultant Nurse in Men's Health/Sexual Medicine PhD

Urological

INVESTING IN VOLUNTEERS

Confidential - Clinical Information

Department of Urology
University Hospital Ayr
Dalmellington Road
Ayr
KA6 6DX
01292 610555

www.nhsayrshireandarran.com

NHS Ayrshire & Arran

Dr JA Taylor
Dalry Medical Practice
Dalry Health Centre
50 Vennel Street
Dalry
KA24 4AF

Our Ref:	DR/LP
Hospital No:	
Clinic Date:	02/11/2012
Date Dictated:	02/11/2012
Date Typed:	06/12/2012
Enquiries to	Maureen McCreadie
Direct Line:	
Ext. Number:	14305
Email:	maureen.mccreadie@aaaht.scot.nhs.uk

Dear Dr Taylor,

STEPHEN GALLOWAY DOB: 14/06/1965 CHI No: 140 665 0854
66 GARNOCK STREET, DALRY, AYRSHIRE, KA24 4AW

Mr Galloway has not contacted me since he failed to attend my Clinic in July.

I assume that he is continuing to respond well to Tadalafil.

I plan no further follow up for him although he has my contact number should he need advice.

Yours sincerely

This document has NOT been verified

Derek Rutherford
Consultant Nurse in Men's Health/Sexual Medicine PhD

Urological

INVESTING IN VOLUNTEERS

Confidential - Clinical Information

Dr JA Taylor
Dalry Medical Practice
Dalry Health Centre
50 Vennel Street
Dalry
KA24 4AF

Dear Dr Taylor,

STEPHEN GALLOWAY
66 GARNOCK STREET, DALRY, AYF

Mr Galloway re-attended my Clinic tod

He failed to respond to 20mg of Tadala
been using the treatment to its best eff
action associated with Tadalafil, he ha

I have again advised him again on how
see him in 4 weeks for review.

Yours sincerely

Authorised on 06/06/2012 12:07:24 by

Derek Rutherford
Consultant Nurse

Confidential - Clinical Information

Department of Urology
University Hospital Ayr
Dalmellington Road
Ayr
KA6 6DX
01292 610555

www.nhsayrshireandarran.com

NHS Ayrshire & Arran

Dr JA Taylor
Dalry Medical Practice
Dalry Health Centre
50 Vennel Street
Dalry
KA24 4AF

Our Ref:	DR/CIK
Hospital No:	100-750249
Clinic Date:	23/05/2012
Date Dictated:	23/05/2012
Date Typed:	04/06/2012
Enquiries to	Ann Anderson
Direct Line:	
Ext. Number:	14305
Email:	ann.anderson@aaaht.scot.nhs.uk

Dear Dr Taylor,

STEPHEN GALLOWAY DOB: 14/06/1965 CHI No: 1406650854
66 GARNOCK STREET, DALRY, AYRSHIRE, KA24 4AW

Mr Galloway re-attended my Clinic today

He failed to respond to 20mg of Tadalafil (Cialis) however, on discussion with him, he has not been using the treatment to its best effect. Despite counselling him on the long duration of action associated with Tadalafil, he had been expecting a response within half and hour.

I have again advised him again on how to use tadalafil and he will adhere to my advice. I will see him in 4 weeks for review.

Yours sincerely

Authorised on 06/06/2012 12:07:24 by Derek Rutherford.

Derek Rutherford
Consultant Nurse

Urological

INVESTING IN VOLUNTEERS

Confidential - Clinical Information

Department of Urology
Erectile Dysfunction Clinic
University Hospital Ayr
Dalmellington Road
Ayr
KA6 6DX
01292 610555
01292 288952
www.nhsayrshireandarran.com

NHS Ayrshire & Arran

Dr Taylor
Dalry Medical Practice
Dalry Health Centre
50 Vennel Street
Dalry
KA24 4AF

Our Ref:	DR/AA
Hospital No:	100750249
Clinic Date:	18/04/2012
Date Dictated:	18/04/2012
Date Typed:	10/05/2012
Enquiries to	Ann Anderson
Direct Line:	
Ext. Number:	ext 14305
Email:	anne.anderson@aaaht.scot.nhs.uk

Dear Dr Taylor,

STEPHEN GALLOWAY DOB: 14/06/1965 CHI No: 1406650854
66 GARNOCK STREET, DALRY, AYRSHIRE, KA24 4AW

Mr Galloway re-attended my clinic today. He was seen at the Urology clinic and Mr Mohammed arranged for him to have scrotal ultrasound, which revealed a small hydrocele but no significant abnormality in terms of the pain he experiences. He told me that the pain is more significant in the left side in the inguinal groin region and when he puts pressure on this area in response to the pain, his pain is often relieved. Since I last saw him he told me he had been commenced on Trazadone, although he has stopped taking the medication soon after it was commenced. I am unsure if he informed that he is no longer taking Trazadone. He last attended my clinic in March 2010 and at that time you had arranged for him to have a trial with 20mgs of Tadalafil (Cialis). He did not buy 20mgs of Tadalafil. He told me that his tablets were confiscated by the police following a domestic incident.

Although he has a good urinary flow, he told me that he experiences pain on micturition and he had thorough examination at the Urology clinic by Mr Mohammed and no abnormality was noted. I will however, copy this letter to Mr Gurun as Mr Gurun may wish to carry out further investigation including cystoscopy. He told me that the pain he experiences severe and often unbearable. From his account of events it certainly merits further investigation. He has had vasectomy and circumcision in the past. He told me that there is no possibility that he has a sexually transmitted infection and he told me he has submitted a urine specimen for routine urine analysis recently. Currently he obtains only a partial erection, which is difficult to sustain. I think it would be reasonable for him to continue with Tadalafil (Cialis) and he will have another trial with 10mgs. I have arranged this for him from my clinic today.

Cont/.....

Urological

INVESTING IN VOLUNTEERS

STEPHEN GALLOWAY

I reiterated the potential side affects including retinal vein occlusion, retinal haemorrhage and loss of vision and I also advised him that hearing loss has been linked to PDE5 Inhibitors. He does not have a history of eye disease. He is smoking 15 cigarettes per day and he takes no alcohol. He told me that he had stopped smoking cannabis. He is not in a relationship and is inhibited about establishing a relationship because of his sexual dysfunction. He keeps himself fit by cycling. I will see him again in five weeks for review and I will keep you updated on his progress.

Yours sincerely

This document has NOT been verified

Derek Rutherford
Consultant Nurse

Cc Mr Gurun, Consultant Urologist

INVESTING IN VOLUNTEERS

D. Rutherford 17/4/12 5pm

CF

Urology Department
Consultant – Mr B Little
The Ayr Hospital
Dalmellington Road
AYR KA6 6DX

NHS Ayrshire & Arran

Clinic Date:	27/02/12
Date Typed:	07/03/12
Our Ref:	MM/KJ/100-750249
CHI No:	1406650854

~~Dr Taylor~~
~~50 Vennel Street~~
~~DALRY~~

Enquiries to:	Miss Karen Johnston
Extension:	14691
Telephone:	01292 610555
Fax:	01292 614609
e-mail:	Karen.johnston@aaaht.scot.nhs.uk

Dear Dr Taylor

RE: STEPHEN GALLOWAY, 66 GARNOCK STREET, DALRY (DOB 14/06/1965)

Thank you for referring this gentleman to the urology clinic. He is complaining of two issues the first one is left testicular pain which is intermittent and been there for the last 6 months. He has no history of any haematuria and he had a vasectomy about 5 years ago with circumcision at the same time. He mentions to me that he has some voiding symptoms. The second issue is erectile dysfunction. He is known to the ED clinic in the past and he has a normal libido but he has loss of morning erections. He is not on any medications and he is a smoker of 15 cigarettes per day. He has no known allergies.

On examination his abdomen and external genitalia were unremarkable. I explained to Mr Galloway that I will organise an ultrasound scan testes to ensure this is all normal. I have arranged for him to have a hormonal profile including Testosterone, Prolactin, FSH and LH. I will ask our specialist ED nurse Derek Rutherford to see him in the neat future.

Yours sincerely

M MOHAMMED
LAT in Urology

MR B LITTLE
Consultant Urological Surgeon
GMC No 4187488

C.C. Derek Rutherford, Specialist Nurse

MEDICAL RECORDS
CROSSHOUSE HOSPITAL
27 MAR 2012

INVESTING IN VOLUNTEERS

Confidential - Clinical Information

Department of Urology
Ayr Hospital
Dalmellington Road
Ayr
KA6 6DX
01292 610555
01292 614609
www.nhsayrshireandarran.com

NHS Ayrshire & Arran

Stephen Galloway
66 Garnock Street
Dalry
Ayrshire
KA24 4AW

Our Ref:	BL/KJ/ **1406650854**
Ref Date:	21/03/2012
Date Dictated:	21/03/2012
Date Typed:	22/03/2012
Enquiries to	Miss Karen Johnston
Direct Line:	
Ext. Number:	14691
Email:	karen.johnston@aaaht.scot.nhs.uk

Dear Mr Galloway,

This is just to let you know that your testicular ultrasound scan was normal which is excellent news.

Yours sincerely

This document has NOT been verified

Mr B Little
Consultant Urological Surgeon
GMC: 4187488

Dr ML Perman
Dalry Medical Practice
Dalry Health Centre
50 Vennel Street
Dalry
KA24 4AF

Urological

INVESTING IN VOLUNTEERING

STA 0616

Confidential - Clinical Information

Department of Urology
Ayr Hospital
Dalmellington Road
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01292 610555
01292 614609
www.nhsayrshireandarran.com

NHS Ayrshire & Arran

Stephen Galloway
66 Garnock Street
Dalry
Ayrshire
KA24 4AW

Our Ref:	BL/KJ/ **1406650854**
Ref Date:	14/03/2012
Date Dictated:	14/03/2012
Date Typed:	16/03/2012
Enquiries to	Miss Karen Johnston
Direct Line:	
Ext. Number:	14691
Email:	karen.johnston@aaaht.scot.nhs.uk

Dear Mr Galloway,

This is just to let you know your recent blood tests were normal, particularly testosterone levels and your Prolactin levels.

Yours sincerely

This document has NOT been verified

Mr B Little
Consultant Urological Surgeon
GMC: 4187488

Dr ML Perman
Dalry Medical Practice
Dalry Health Centre
50 Vennel Street
Dalry
KA24 4AF

Urological

INVESTING IN VOLUNTEERING

Urology Department
Consultant – Mr B Little
The Ayr Hospital
Dalmellington Road
AYR KA6 6DX

NHS Ayrshire & Arran

Clinic Date: 27/02/12
Date Typed: 07/03/12
Our Ref: MM/KJ/100-750249
CHI No: 1406650854

Dr Taylor
50 Vennel Street
DALRY

Enquiries to: Miss Karen Johnston
Extension: 14691
Telephone: 01292 610555
Fax: 01292 614609
e-mail: Karen.johnston@aaaht.scot.nhs.uk

Dear Dr Taylor

RE: STEPHEN GALLOWAY, 66 GARNOCK STREET, DALRY (DOB 14/06/1965)

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Yours sincerely

M MOHAMMED
LAT in Urology

MR B LITTLE
Consultant Urological Surgeon
GMC No 4187488

C.C. Derek Rutherford, Specialist Nurse

Urological

INVESTING IN VOLUNTEERS

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 1010029350870

REFERRAL LETTER

CHI:1406650854

MEDICAL IN CONFIDENCE

REFERRAL TO

UrologyCB
AA Gen Ref - PMH Med & High

Ayr Hospital
Dalmellington Road
Ayr
KA6 6DX

Ethnic Origin	(White) Scottish
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	14-Dec-2011
Date submitted	20-Dec-2011

PATIENT DETAILS

Surname	Galloway
Forename(s)	Stephen
Title	-
Sex	Male
Date of birth	14-Jun-1965
CHI no.	1406650854

Patient's address

66 Garnock St
Dalry
KA24 4AW

Contact number(s)

Voice: 07511 670274

REGISTERED GP DETAILS

Name	Dr Michael Perman		
GMC code	6056072	GP code	20087
Practice name	Dalry Health Centre		
Practice code	80217		

Practice address

50 Vennel Street
Dalry

Contact number(s)

Voice: 01294-832523
Facsimile: 01294-835771

REFERRING PRACTITIONER DETAILS

Name	Dr. James Taylor		
GMC code	1350799	GP code	20648
Practice name	Dalry Medical Practice (80217)		
Practice code	80217		

Practice address

Dalry Health Centre
50 Vennel Street
Dalry
KA24 4AF

Contact number(s)

Voice: 01294 832523
Facsimile: 01294 835771

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: Episodic pains at base of penis

Comment: The above 46 year old gentleman complains of episodic severe pains at the base of his penis on the left hand side for the past several months. This tends to come on with movement. He denies any particular problems with micturition or similar. He does have a past history of vasectomy and circumcision in 2005. Circumcision being performed for recurrent episodes of balanitis and irritation of foreskin.When I examined him today I am afraid I could detect no gross abnormality and I am not sure what this pain is but I would be grateful for your help.Yours sincerelyDr James A Taylor

Examinations and Investigations

Height:	167	-
Weight(kg):	67	-
BMI:	24.02	-
Current smoker:		20-Oct-2011 00:00
Alcohol consumption, 0 units/week:		20-Oct-2011 00:00

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Anxiety states	-	-	-	10-Dec-2010	10-Dec-2010
Erectile dysfunction	-	-	-	26-Feb-2008	26-Feb-2008
Cause of overdose - deliberate	-	-	drank bottle of disinfectant & alcohol	21-Jul-2001	21-Jul-2001
Death of son	-	-	age 10 - alcohol overdose	18-Oct-1997	18-Oct-1997
Alcohol dependence syndrome	-	-	-	17-Jun-1997	17-Jun-1997
Depressed	-	-	-	05-May-1997	05-May-1997
H/O: deliberate self harm	-	-	stabbing to abdomen	05-Apr-1997	05-Apr-1997
Cause of overdose - deliberate	-	-	paracetamol x 24 & alcohol	07-Jan-1996	07-Jan-1996
Query H/O: asthma	Uncertain	-	no recent evidence of asthma	20-Apr-1988	20-Apr-1988

Past procedures

Description	Laterality	Modifier	Comments	Date performed	Recorded Date
Internal fixation of bone NEC	-	-	# zygomatic bone	07-Jul-2006	07-Jul-2006
Bilateral vasectomy for contraception	-	-	-	22-Apr-2005	22-Apr-2005
Standard circumcision	-	-	-	22-Apr-2005	22-Apr-2005
Upper Gastrointestinal endoscopy	-	-	reflux oesophagitis, gastric ulcer, gastritis	11-Oct-1999	11-Oct-1999
Helicobacter pylori test positive	-	-	-	11-Oct-1999	11-Oct-1999

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date

Trazodone Hydrochloride Tablets 150 mg	0403010X0AAADAD	28 TABLET	ONE TO BE TAKEN AT NIGHT	-	10-Nov-2011	42 Days	13-Dec-2011
Trazodone Hydrochloride Tablets 150 mg	0403010X0AAADAD	28 TABLET	ONE TO BE TAKEN AT NIGHT	-	13-Oct-2011	28 Days	13-Oct-2011

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status

Number per day
? (not known)

Alcohol consumption

Units per day
? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

Social circumstances

Signature of referring doctor (or other professional) **Date**

STA 0616

The Ayr Hospital
Dalmellington Road
AYR
KA6 6DX

☎ : 01292 610555

ERECTILE DYSFUNCTION CLINIC

DEREK RUTHERFORD
Specialist Nurse

Date Attended: 12/08/10
Date Typed: 02/09/10
Our Ref: DR/AA/750249
CHI No: 1406650854
Enquiries to: Mrs A Anderson
Extension: 14305
Fax: 01292 614537
E-mail: ann.anderson@aaaht.scot.nhs.uk

Dr Hillman
Kilbirnie Health Centre
2 Kirkland Road
Kilbirnie

Dear Dr Hillman

STEPHEN GALLOWAY 12 CASTLE DRIVE KILBIRNIE D.O.B. 14/6/65

Mr Galloway failed to attend my clinic on 10th August for review. He also failed to previous review appointments. I therefore plan no further follow-up for him. I assume he is continuing to respond well to Tadalafil.

Yours sincerely

DEREK RUTHERFORD
SPECIALIST NURSE IN UROLOGY

[redacted]

Urological

[redacted]

JMcC/60799

The Ayr Hospital
Dalmellington Road
AYR
KA6 6DX

☎ : 01292 610555

ERECTILE DYSFUNCTION CLINIC

DEREK RUTHERFORD
Specialist Nurse

Date Attended: 23/03/10
Date Typed: 07/04/10
Our Ref: DR/AA/750249
CHI No: 1406650854
Enquiries to: Mrs A Anderson
Extension: 14305
Fax: 01292 614537
E-mail: ann.anderson@aaaht.scot.nhs.uk

Dr R Hillman
The Surgery
2 Kirland Road
Kilbirnie

Dear Dr Hillman

STEPHEN GALLOWAY 12 CASTLE DRIVE KILBIRNIE D.O.B. 14/6/65

Thank you for re-referring this 43 year old gentleman to the Sexual Dysfunction Clinic. I last saw him on 21st May 2009 and at that time he was responding well to 100mgs of Sildenafil Citrate. He was also continuing on pelvic floor exercises. He failed to attend for follow-up. On discussion with him today he told me that you prescribed Tadalafil (Cialis 10mgs) for him and he failed to respond. I have therefore advised that he should try 20mgs of Tadalafil and I arranged this for him today via my clinic. I will see him in five weeks for review and I will keep you updated on his progress. He is in similar predicament to when I last saw him. He is with the same partner and he has had no health problems or been commenced on medication since I last saw him. He told me that he began to experience ED following vasectomy and that when I initially saw him he was experiencing complete, global ED. He is a smoker but he takes no alcohol. However, he drank alcohol heavily in the past. He had his hormone profile checked in March 2008 and his total testosterone was healthy measuring 34.0nmol/l.

I will keep you updated on his progress.

Yours sincerely

DEREK RUTHERFORD
SPECIALIST NURSE IN UROLOGY

The Ayr Hospital
Dalmellington Road
AYR
KA6 6DX

☎ : 01292 610555

ERECTILE DYSFUNCTION CLINIC

DEREK RUTHERFORD
Specialist Nurse

Date Attended: 22/03/10
Date Typed: 19/04/10
Our Ref: DR/AA/750249
CHI No: 1406650854
Enquiries to: Mrs A Anderson
Extension: 14305
Fax: 01292 614537
E-mail: ann.anderson@aaaht.scot.nhs.uk

Dr R G Hillman
The Helath Centre
2 Kirkland Road
Kilbirnie

Dear Dr Hillman

STEPHEN GALLOWAY 12 CASTLE DRIVE KILBIRNIE D.O.B. 14/6/65

Thank you for re-referring this gentleman to the Sexual Dysfunction Clinic. I last saw him in May 2009 and he told me that he was responding to Sildenafil Citrate 100mgs. However, apparently his response to Sildenafil has deteriorated. You prescribed Tadalafil (Cialis) 10mgs for him and he did not respond. I have therefore had a long discussion with him and he will try 20mgs of Tadalafil. I advised that if he fails to respond to Tadalafil I will arrange for him to have a trial with Vardenafil (Levitra). I have also advised him on the alternative treatments to oral therapy.

I will see him again in six weeks for review and I will keep you updated on his progress.

Yours sincerely

DEREK RUTHERFORD
SPECIALIST NURSE IN UROLOGY

Urological

C/F

Hospital Use Only	Clinic	Day Date	Time	Hospital No. 750249	GP112

REQUEST FOR OUT-PATIENT CONSULTATION
THE INFORMATION IN THIS SECTION MUST BE COMPLETED

Appointment Category: Routine ☑ Soon ☐ Urgent ☐

CHI No. 1406650854

PARTICULARS OF PATIENT IN BLOCK LETTERS PLEASE

Hospital Ayr Date 15 01 2010

Please arrange for this patient to attend the Erectile Dysfunction clinic of Dr/Mr D Rutherford

Patient's Surname Galloway Maiden Surname

First Names Stephen Single/Married/Widowed/Other

Address 12 Castle Drive, KILBIRNIE, KA25 6AT Date of Birth 14/06/1965

Patient's Occupation

Postal Code Contact telephone number 01505 685230

Has the patient attended hospital before? YES / NO If "YES" please state:

Name of Hospital

Year of attendance Hospital No.

If the patient's name and/or address has/have changed since then please give details:

Can patient attend at short notice YES / NO

If YES, minimum notice required days

Name, Address and Telephone number of MEDICAL / DENTAL PRACTITIONER

Dr R Hillman
Kilbirnie Medical
Practice
2 Kirkland Road
Kilbirnie
Ayrshire
KA25 6HS
01505 683591

Please use rubber stamp

A80363

I would be grateful for your opinion and advice on the above named patient. A brief outline of history, symptoms and signs is given below:

Dear Derek

You discharged the abovenamed gentleman because he failed to attend 2 clinic appointments. He has attended again today saying his erectile failure continues despite treatment and saying that he is keen to continue exploring other options. I have pointed out to him that not going to the clinic isn't a very good way to achieve this and he has undertaken to attend, should you agree to send him another appointment. I would be grateful, therefore, if you would consider reappointing him.

Yours sincerely

Dr R Hillman

Diagnosis / provisional diagnosis:

Present drug treatment and potential special hazards:

X-ray (women of childbearing age). Date of first day of L.M.P.

Relevant X-rays available from: No. (if known)

AYR HOSPITAL
27 JAN 2010
ADDED TO OUTPATIENTS WAITING LIST

Signature

Printed for Astron B48904, 10/06 25364

355-2104

The Ayr Hospital
Dalmellington Road
AYR
KA6 6DX

☎ : 01292 610555

ERECTILE DYSFUNCTION CLINIC

DEREK RUTHERFORD
Specialist Nurse

Date Attended: 11/12/09
Date Typed: 21/12/09
Our Ref: DR/AA/750249
CHI No: 1406650854
Enquiries to: Mrs A Anderson
Extension: 14305
Fax: 01292 614537
E-mail: ann.anderson@aaaht.scot.nhs.uk

Dr R G Hillman
The Helath Centre
2 Kirkland Road
Kilbirnie

Dear Dr Hillman

STEPHEN GALLOWAY 12 CASTLE DRIVE KILBIRNIE D.O.B. 14/6/65

Mr Galloway failed to attend my clinic for review on 3rd November 2009. He also failed to attend in August. I assume he is continuing to respond to Sildenafil Citrate. I plan no further follow-up for him but he has my contact number should he need advice.

Yours sincerely

DEREK RUTHERFORD
SPECIALIST NURSE IN UROLOGY

Urological

The Ayr Hospital
Dalmellington Road
AYR
KA6 6DX

☎ : 01292 610555

ERECTILE DYSFUNCTION CLINIC

DEREK RUTHERFORD
Specialist Nurse

Date Attended: 21/05/09
Date Typed: 03/06/09
Our Ref: DR/AA/750249
CHI No: 1406650854
Enquiries to: Mrs A Anderson
Extension: 14305
Fax: 01292 614537
E-mail: ann.anderson@aaaht.scot.nhs.uk

Dr R G Hillman
The Helath Centre
2 Kirkland Road
Kilbirnie

Dear Dr Hillman

STEPHEN GALLOWAY 12 CASTLE DRIVE KILBIRNIE D.O.B. 14/6/65

Mr Galloway re-attended my clinic today for review. He is responding to 100mgs of Sildenafil Citrate and is also continuing with pelvic floor exercises. He has experienced no side affects with the treatment and both he and his partner are happy with his response. He will continue with 100mgs of Sildenafil Citrate meantime and he will discuss with you the possibility of prescribing the treatment for him. He is aware of the NHS guidance pertaining to the treatment of ED.

I will see him in six weeks and I will keep you updated on his progress.

Yours sincerely

DEREK RUTHERFORD
SPECIALIST NURSE IN UROLOGY

Urological

The Ayr Hospital
Dalmellington Road
AYR
KA6 6DX

☎ : 01292 610555

ERECTILE DYSFUNCTION CLINIC

DEREK RUTHERFORD
Specialist Nurse

Date Attended: 27/11/08
Date Typed: 08/01/09
Our Ref: DR/AA/750249
CHI No: 1406650854
Enquiries to: Mrs A Anderson
Extension: 4305
Fax: 01292 265265
E-mail: ann.anderson@aaaht.scot.nhs.uk

Dr R G Hillman
The Health Centre
2 Kirkland Road
Kilbirnie

Dear Dr Hillman

STEPHEN GALLOWAY 12 CASTLE DRIVE KILBIRNIE D.O.B. 14/6/65

Mr Galloway re-attended my clinic today. He failed to attend an appointment in September. He used 50mgs of Sildenafil Citrate and although he gained full tumescence his erection was short-lived. He was therefore keen to increase the dose to 100mgs. He experienced no side affects with 50mgs apart from facial flushing. I will therefore 100mgs of Sildenafil from clinic. He is continuing with pelvic floor exercises. I will see him in six weeks for review and I will keep you updated on his progress.

Yours sincerely

DEREK RUTHERFORD
SPECIALIST NURSE IN UROLOGY

Urological

The Ayr Hospital
Dalmellington Road
AYR
KA6 6DX

☎ : 01292 610555

ERECTILE DYSFUNCTION CLINIC

DEREK RUTHERFORD
Specialist Nurse

Date Attended: 24/07/08
Date Typed: 06/08/08
Our Ref: DR/AA/750249
CHI No: 1406650854
Enquiries to: Mrs A Anderson
Extension: 4305
Fax: 01292 265265
E-mail: ann.anderson@aaaht.scot.nhs.uk

Dr Hillman
Kilbirnie Health Centre
2 Kirkland Road
Kilbirnie

Dear Dr Hillman

STEPHEN GALLOWAY 12 CASTLE DRIVE KILBIRNIE D.O.B. 14/6/65

Thank you for this pleasant 43 year old gentleman to the Sexual Dysfunction Clinic. Mr Galloway has experienced ED since he had vasectomy and circumcision. His vasectomy was carried out two years ago. I noticed he attended the Urology clinic in Ayr Hospital but failed to attend for follow-up. I am unsure of where is vasectomy was done. He told me that he does not gain any form of tumescence, however his sexual drive and desire remain intact. He can ejaculate and maintains orgasmic sensation . He has also noticed pain after he ejaculates for about 15 minutes but he told me that this is a dull ache and it is not great significance. He smokes about 15 cigarettes per day and takes no alcohol. He took alcohol in excess in the past. I understand you checked his BP prior to his referral. He has never taken long-term recreational drugs. He is not on any medication and he denies lower urinary tract symptoms. He refused physical examination and told me that he examines himself and had noticed no genital abnormalities. I note you checked his total testosterone, which was within normal limits measuring 34.0nmol/l. Random glucose was 4.7 and his U&Es and LFTs were essentially normal. FBC was also normal.

I have advised him on the potential causes of his ED including his smoking and alcohol consumption. He associates his surgery with the problem that this may have just been a contributory factor. He apparently recent urine analysis, which revealed no abnormalities. I have given him advice on pelvic floor exercises and he is keen to have a trial with a PDE5 Inhibitor. I think this is reasonable given the severity of his erectile dysfunction. I will arrange dose titration with Sildenafil Citrate from my clinic and I will review his progress in six weeks.

Yours sincerely

DEREK RUTHERFORD
SPECIALIST NURSE IN UROLOGY

Urological

The Ayr Hospital
Dalmellington Road
AYR
KA6 6DX

☎ : 01292 610555

ERECTILE DYSFUNCTION CLINIC

DEREK RUTHERFORD
Specialist Nurse

Date Attended: 01/07/08
Date Typed: 16/07/08
Our Ref: DR/AA/750249
CHI No: 1406650854
Enquiries to: Mrs A Anderson
Extension: 4305
Fax: 01292 265265
E-mail: ann.anderson@aaaht.scot.nhs.uk

Dr R G Hillman
The Helath Centre
2 Kirkland Road
Kilbirnie

Dear Dr Hillman

STEPHEN GALLOWAY 12 CASTLE DRIVE KILBIRNIE D.O.B. 14/6/65

Thank you for referring this gentleman to the Sexual Dysfunction Clinic. He failed to attend his appointment on 18th June 2008, I therefore plan no further follow-up for him. If he requests re-referral please let me know and I will gladly see him.

Yours sincerely

DEREK RUTHERFORD
SPECIALIST NURSE IN UROLOGY

Urological

CONSENT TO TREATMENT

SILDENAFIL CITRATE/VARDENAFIL/TADALAFIL

I am aware that I cannot take any form of nitrate therapy including Amilnitrate when using a PDE5 Inhibitor.

I am aware that if I experience chest pain I need to inform whoever is treating me that I am using a PDE5 Inhibitor.

I do not have peptic or duodenal ulcer.

I am aware of the side effects and contra-indications to using PDE5 Inhibitor.

I do not have hereditary eye disease. I do not have liver or kidney damage.

A very rare association between medications for erectile dysfunction and visual disturbance has been described in the medical literature. The risk is very small but the consequence may be permanent loss of vision. The primary risk factor is believed to be a birth defect which occurs in a minority of people. If you are concerned about the risk of vision loss, an ophthalmologic examination could confirm the presence of this defect. There has also been concern that the above drugs may contribute to hearing loss.

PRINT NAME STEPHEN GALLOWAY

SIGNATURE S Galloway **DATE** 17/4/2012

450249

Hospital Use Only	Clinic	Day Date	Time	Hospital No.	GP112

REQUEST FOR OUT-PATIENT CONSULTATION
THE INFORMATION IN THIS SECTION MUST BE COMPLETED

Appointment Category: Routine ☑ Soon ☐ Urgent ☐

Hospital: AYR — Date: 19 03 2008 — CHI No.: 1406650854

Please arrange for this patient to attend the: Erectile Dysfunction Out Patient clinic of Dr/Mr: D. Rutherford / Meddings

PARTICULARS OF PATIENT IN BLOCK LETTERS PLEASE

Patient's Surname: Galloway — Maiden Surname:

First Names: Stephen — Single/Married/Widowed/Other:

Address: 12 Castle Drive, KILBIRNIE, KA256AT — Date of Birth: 14/06/1965

Patient's Occupation:

Postal Code: — Contact telephone number: 07742699046

Has the patient attended hospital before? YES / NO If "YES" please state:

Name of Hospital:

Year of attendance: Hospital No.:

If the patient's name and/or address has/have changed since then please give details:

Can patient attend at short notice YES / NO

If YES, minimum notice required: days

Name, Address and Telephone number of MEDICAL / DENTAL PRACTITIONER

Dr R. Hillman
Kilbirnie Medical
Practice
2 Kirkland Road
Kilbirnie
Ayrshire
KA25 6HS
01505 683591

Please use rubber stamp

A80363

I would be grateful for your opinion and advice on the above named patient. A brief outline of history, symptoms and signs is given below:

Dear Derek,

I would be very grateful for your help with the management of Stephen who presents with complete erectile failure of approximately one year duration despite being only 42 years of age. This is causing significant problems with his relationship and he is looking for some help accordingly. He had a vasectomy approximately two years ago, noticed a decline in erectile function and then feels it stopped quite abruptly thereafter. Mr Galloway used to drink a fair amount of alcohol, although he hasn't in several years. He is a smoker and I have advised him to stop. Routine bloods were all normal and Mr Galloway is on no medication to account for his current symptoms.

Past medical history includes: a suicide attempt. Allergies – nil. Blood results attached.

Yours sincerely,

Dr. Robert Hillman.

AYR HOSPITAL
11 APR 2008
ADDED TO OUTPATIENTS WAITING LIST

RECEIVED
25 MAR 2008

Diagnosis / provisional diagnosis:

31/3/08

	URGENT	SOON	ROUTINE
GENERAL APPOINTMENT			
PAEDIATRIC APPOINTMENT			
X-RAY ON ARRIVAL			
HAEM-FLEXI MACRO			
CONTINENCE			
E.D.			
FLEXI			✓
PROSTATE			
TRUS			
VASECTOMY			

No. (if known)

Signature

355-2104

SURNAME GALLOWAY FORENAME STEPHEN D.O.B 14.06.65 SEX Male	UNIT No. ZNC0855242 CHI No. 1406650854 ADDRESS 12 CASTLE DR NEWMILNS	CONS/GP HILLMAN DESTINATION BIOCHEMISTRY CROSSHOUSE Kilbirnie

	DATE / TIME					
		06.03.08 08:45				
LH *U/L*	*(See Handbook)*					
FSH *U/L*	*(See Handbook)*					
Prolactin *mU/L*	*(<400)*					
Oestradiol *pmol/L*	*(See Handbook)*					
Progesterone *nmol/L*	*(See Handbook)*					
Testosterone *nmol/L*	*(10.0-36.0)*	34.0				
SHBG *nmol/L*	*(13-70)*	57				
FAI						

601913

Dept of Clinical Biochemistry
North Glasgow Sector
NHSGGC

Laboratory Number
4062885

Collected
DATE 06.03.08
TIME 08:45

Received
DATE 07.03.08
TIME 15:47

Report Issued
DATE 10.03.08
TIME 12:55

Authorised by
Dr Jennifer Logue

CPA
Accredited Medical Laboratory
Reference No:2335

601913 Satisfactory Result 13/03/08 13:11

Gonadal Hormones

NHS Ayrshire & Arran General Hospital Division — Area Laboratory — Clinical Biochemistry

GALLOWAY	*Patient No.* 1406550854	*Clinician*	Dr R G Hillman
STEPHEN	*Unit No.*	*Request Location*	The Health Centre
12 CASTLE DRIVE	*DOB* 14/06/1965		2 Kirkland Road
NEWMILNS KA25 6AT	*Sex* M		Kilbirnie

This Report To **Dr R G Hillman GP, Kilbirnie Health Centre**

Blood Specimen

Free T4	14.8	*pmol/l*	TSH	1.28	*mU/l*
LH	6.0	*U/l*	FSH	2.6	*U/l*
Prolactin	146	*mU/l*			

Satisfactory Result 10/03/08 14:08

Lab No B.08.105795 *Date/Time Coll* 06/03/2008 08:45

Printed 07/03/2008 10:24 *Page* 1 OF 1

If you have received this report in error, please return to the Clinical Biochemistry Laboratory

NHS Ayrshire & Arran General Hospital Division

Area Laboratory — Blood Transfusion

GALLOWAY
STEPHEN
12 CASTLE DRIVE
NEWMILNS KA25 6AT

Patient No. 1406650854
Unit No.
DOB 14/06/1965
Sex M

Clinician Dr R G Hillman
Location The Health Centre
2 Kirkland Road
Kilbirnie

This Report To Dr R G Hillman GP, Kilbirnie Health Centre

Satisfactory Result 10/03/08 08:05

	Result	Units	Normal Range
Hb	14.7	g/dl	13.5-18.0
WBC	11.2	x 10^9/l	4.0-11.5
Plts	267	x 10^9/l	150-450
RBC	4.69	x 10^12/l	4.20-6.50
Hct	0.430		0.400-0.550
MCV	91	fl	79-100
MCH	31.3	pg	25.0-32.0
MCHC	34.4	g/dl	30.0-36.0
Neutrophils	6.5	x 10^9/l	1.5-7.5
Lymphocytes	3.2	x 10^9/l	1.5-4.0
Monocytes	1.0	x 10^9/l	0.2-1.0
Eosinophils	0.5	x 10^9/l	0.0-0.5
Basophils	0.1	x 10^9/l	0.0-0.1

Date Collected 06/03/2008
Time Collected 08:45

Sample Type Blood
Lab No. 9 08 105795

Printed 06/03/2008 14:57

If you have received this report in error please return to the Blood Transfusion Laboratory

NHS Ayrshire & Arran General Hospital Division — Area Laboratory — Clinical Biochemistry

GALLOWAY
STEPHEN
12 CASTLE DRIVE
NEWMILNS KA25 6AT

Patient No. 1406650854
Unit No.
DOB 14/06/1965
Sex M

Clinician Dr R G Hillman
Request Location The Health Centre
2 Kirkland Road
Kilbirnie

This Report To Dr R G Hillman GP, Kilbirnie Health Centre

Blood Specimen

Urea	6.4		mmol/l	Creatinine	108		µmol/l
Sodium	142		mmol/l	Potassium	4.6		mmol/l
Chloride	103		mmol/l	Bicarbonate	27		mmol/l
Glucose	4.7		mmol/l	Total Bilirubin	10		µmol/l
Alkaline Phos.	62		U/l	AST	30		U/l
ALT	27		U/l	Total Protein	83		g/l
Albumin	47		g/l	Globulin	36	Hi	g/l
Calcium	2.36		mmol/l	Corr.Calcium	2.13		mmol/l
Phosphate	0.76	Lo	mmol/l				

Satisfactory Result 10/03/08 08:05

Lab No B.08.105795 *Date/Time Coll* 06/03/2008 08:45

Printed 06/03/2008 16:12 *Page* 1 OF 1

If you have received this report in error, please return to the Clinical Biochemistry Laboratory

NHS Ayrshire & Arran General Hospital Division — Area Laboratory — Clinical Biochemistry

GALLOWAY	*Patient No.* 1406650854	*Clinician*	Dr R G Hillman
STEPHEN	*Unit No.*	*Request Location*	The Health Centre
12 CASTLE DRIVE	*DOB* 14/06/1965		2 Kirkland Road
NEWMILNS KA25 6AT	*Sex* M		Kilbirnie

This Report To **Dr R G Hillman GP, Kilbirnie Health Centre**

Testosterone	N/A	Specimen sent to external laboratory. A final report will follow.
Sex Hormone Binding Globulin	N/A	Specimen sent to external laboratory. A final report will follow.

No Action Required 10/03/08 08:05

Lab No B.08.601913 *Date/Time Coll* 06/03/2008 08:45

Printed 06/03/2008 17:04 *Page* 1 OF 1

If you have received this report in error, please return to the Clinical Biochemistry Laboratory

Ayrshire & Arran Acute Hospitals NHS Trust
The Ayr Hospital
Dalmellington Road
Ayr
Tel : 01292 610555

03/11/03 Patient's Unit Number: A100750249

G (GP) MCAFEE
KILBIRNIE HEALTH CENTRE
2 KIRKLAND ROAD
KILBIRNIE
KA256HP

Dear Doctor

Re : STEPHEN GALLOWAY
12 CASTLE DRIVE KILBIRNIE
DATE OF BIRTH : 14/06/65

I write to advise you that the above patient has been removed from my waiting list for the under-noted reason :

1. PATIENT REQUEST
2. CONSULTANT DECISION
3. PATIENT DIED
4. PATIENT MOVED OUT OF AREA
5. MEDICALLY UNFIT FOR SURGERY
6. REPEATED DID NOT ATTEND – 16/1/03 x 30/10/03

Yours sincerely

M. GURUN

A100-750249

H GALLOWAY STEPHEN
12 CASTLE DRIVE
C 1406650854
KILBIRNIE
S KA256AT 14/06/1965
F HILLMAN,RG (GP)
A KILBIRNIE HEALTH CENTRE
2 KIRKLAND ROAD
... KILBIRNIE M/N
Date of Birth

STA1060

DATE

UROLOGICAL

JMcG/74063

DATE

4/9/08

21/11/08

15/1/09

2/8/09

Write or attach label

A100-750249
GALLOWAY STEPHEN
12 CASTLE DRIVE
1406650854
KILBIRNIE
KA256AT 14/06/1965
HILLMAN,RG (GP)
KILBIRNIE HEALTH CENTRE
2 KIRKLAND ROAD
KILBIRNIE M/N
Date of Birth

STA1060

DATE

21/5/~

11/8/09

IROLOGICAL

DATE

3/11/09

2/3/10

2/4/10

10/8/10

Write or attach label

A100-750249
GALLOWAY STEPHEN
12 CASTLE DRIVE
1406650854
KILBIRNIE
KA256AT 14/06/1965
HILLMAN,RG (GP)
KILBIRNIE HEALTH CENTRE
2 KIRKLAND ROAD
KILBIRNIE M/N
Date of Birth

STA1060

DATE

27/2/12 BL Clinic

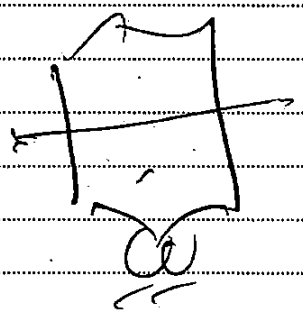
① bothell. intermittent for 6/12. No haematuria. radiotherapy about 5y. had circumcision. No urinary tract symptoms.

PMH
No HTN.
No angina.
No stroke.
No DM.
No COPD.

PSH
radiotherapy
+ circumcision.

No allergies

15/12 pill up.
number + decision.



SD

② CXR
GTD referral
hormonal assay

decline

UROLOGICAL

JMcCF74063

DATE

17/4/12 c/o

Write or attach label

HCR N
CHI: 1406650854
CHI No Galloway, Stephen
Surnan 66 Garnock Street
Dalry
Forena KA24 4AW
Addres: 14/06/1965
Dr ML Perman
MRN: A100750249
Date of Birth

STA1060

DATE

DATE

(7/7/12

THE AYR HOSPITAL
Medical Imaging Department
Dalmellington Road
Ayr
KA6 6DX

NHS Ayrshire & Arran

750249
P

RADIOLOGY REPORT

CHI NUMBER: 1406650854 **Examination Number:** 31569214 **Examination Date:** 12/03/2012
Name: GALLOWAY, STEPHEN DOB: 14/06/1965
Address: 66 Garnock Street, Dalry, , KA24 4AW -- **CC:** -
Referring Department / Location: Urology Out Patients
Referring Consultant: Little.Brian
Date Dictated: 12/03/2012 **Typed by:** None
Examination: US Testes

Clinical Indication

Patient with left testicular pain.
Normal exam

BC 21/3/12

Report:

Both testes and epididymi appear normal.

There is a small right sided hydrocele.

Dictating Radiologist / Clinical Specialist **Stacy McVie (Sonographer)**

Verified by: Stacy McVie (Sonographer)

Day Surgery & Endoscopy Proforma

NHS Ayrshire & Arran

Surname:	CALLOWAY
Forename:	STEVIE
Date of Birth:	14 6 65
Permanent Address:	28 KEDBURN PLACE IRVINE
Postal Code:	KA12 9DH
Home Telephone Number:	
Work Telephone Number:	
Mobile Telephone Number:	07468337782
Please specify your preferred contact telephone number:	Home / (Mobile) / Work (delete as required)
Religion:	
General Practitioner (GP) Address:	4 FRY TERRACE
Have you lived in the UK for the last 12 months?	(Yes) / No (delete as required)
Next of Kin Name: HUGH CALLOWAY Relationship: BROTHER	
Next of Kin Tel No:	
Transport home (if not Next of Kin): Name:	Tel No:

Ethnic Origin:

White Scottish	✓
White English	
White Welsh	
White Northern Irish	
White Southern Irish	
Other British	
Prefer not to say	
Polish	
Other white ethnic group	
Any mixed or multiple ethnic groups	
Pakistani, Pakistani Scottish or Pakistani British	
Indian, Indian Scottish, Indian British	

Please tick as appropriate √

Bangladeshi, Bangladeshi Scottish or Bangladeshi British	
Chinese, Chinese Scottish or Chinese British	
Other Asian, Asian Scottish or Asian British	
African, African Scottish or African British	
Other African	
Caribbean, Caribbean Scottish or Caribbean British	
Other Caribbean or Black	
Arab, Arab Scottish or Arab British	
Other ethnic group	
Gypsy/Traveller	

Signed: S Calloway

Date: 18/5/21

Confidential - Clinical Information

Combined Assessment Unit.
Department of Acute Medicine
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
01563 826838

www.nhsaaa.net

NHS Ayrshire & Arran

Dr TG Miller
Frew Terrace Surgery
9 Frew Terrace
Irvine
Ayrshire
KA12 9DY

Our Ref:	GMcK/NG
Hospital No:	
Date Dictated:	18/06/2024
Date Typed:	19/06/2024
Enquiries to	Laura MacAskill-Gilles
Direct Line	01563 826838
Ext. Number	26838
Email	Laura.MacAskill-Gillies@aapct.scot.nhs.uk

Dear Dr Miller,

STEPHEN GALLOWAY DOB: 14/06/1965 CHI No: 1406650854
28 REDBURN PLACE, IRVINE, AYRSHIRE, KA12 9BH

ADMITTED: 11/06/2024

COMMENTS:

This 58 year old man was reviewed in the medical department following a collapse at home. He could not remember exactly what happened but had admitted hard drinking prior to presenting and has a background of alcohol excess. He also reported that he felt more breathless than usual, he has a background of COPD, and his blood tests suggested that he had an infection with white cell count of 14.5 x 10^9 and CRP 205. He was initially treated with antibiotics for a chest infection along with treatment for alcohol withdrawal, however he discharged himself against medical advice without ongoing treatment. He was felt to have capacity to do so by the emergency department team who assessed him prior to his discharge.

Yours sincerely

Authorised on 20/06/2024 12:40:35 by Gordon McKinnon.

Gordon McKinnon
ST7 in Acute Medicine
GMC: 7421162

INVESTING IN VOLUNTEERS

University Hospital Crosshouse,
Kilmarnock Road,
Kilmarnock,
KA2 0BE
Phone : 01563 521133

Immediate Discharge Letter & Prescription

NHS Ayrshire & Arran

To: Miller, Dr. TG,
9 FREW TERRACE,
IRVINE,
KA12 9DY

Re: STEPHEN GALLOWAY
28 REDBURN PLACE,IRVINE,AYRSHIRE,KA12 9BH

DOB: 14/06/1965
Hosp. No.: 1406650854
CHI No.: 1406650854

Date of Admission: 12/10/2023
Ward: WARD 3D - XH
Mode of Admission: Emergency Admission
Consultant: DR ENES MUAZZEN (Gastroenterology)
Admission Reason: Chest pain
Estimated Discharge Date: 18/10/2023
Follow-up:

RECEIVED
18

Primary Diagnosis:

Secondary Diagnoses: COPD
ETOH dependence *last updated 18/10/2023; 4:54 pm by DR RACHAEL ELLIS*

Investigations: Troponin 9-10

K+2.9, Na 127

ECG NSR

CXR nil acute *last updated 18/10/2023; 4:54 pm by DR RACHAEL ELLIS*

Clinical Progress: Dear Doctor,

This patient was admitted with chest pain and alcohol intoxication following a recent admission which the patient self discharged against medical advice.

Troponin and ECG were unremarkable.

Bloods showed hypokalaemia and the patient was treated with IV electrolyte replacement and commenced on GMAWS regime for ETOH withdrawal.

Mr Galloway absconded on the at 05:30 17/10/23. The police were informed. Our anticipated plan was to monitor bloods to ensure potassium levels adequate prior to discharge.

Thank you for your continuing care of this patient.

Kind regards,
Gastro Team

last updated 18/10/2023; 4:54 pm by DR RACHAEL ELLIS

Pharmacy: Patient absconded *last updated 18/10/2023; 4:55 pm by DR RACHAEL ELLIS*

Further patient/drug notes:

Allergy/Intolerance	Reaction
No known drug allergies	

Allergy records are as recorded at time and date of printing

Drug	Dose	Route	Frequency	Days Supply	GP to continue

Discharged by : DR RACHAEL ELLIS
Grade: Foundation Year 1
Dispensed by:
Date:
Checked by:

University Hospital Crosshouse,
Kilmarnock Road,
Kilmarnock,
KA2 0BE
Phone : 01563 521133

Immediate Discharge Letter
&
Prescription

NHS Ayrshire & Arran

To: Miller, Dr. TG,
9 FREW TERRACE,
IRVINE,
KA12 9DY

Re: STEPHEN GALLOWAY
28 REDBURN PLACE,IRVINE,AYRSHIRE,KA12 9BH

DOB: 14/06/1965
Hosp. No.: 1406650854
CHI No.: 1406650854

AMITRIPTYLINE 25 mg Tablets	**50 mg**	Oral	ONCE daily at 10pm	Patients Own Supply	Yes
LANSOPRAZOLE 30 mg Capsules	**30 mg**	Oral	ONCE daily at 7am	Patients Own Supply	Yes
SALBUTAMOL 100 micrograms (MDI) per metered dose	**200 microgram**	Inhalation	WHEN REQUIRED - FOR BREATHLESSNESS	Patients Own Supply	Yes
THIAMINE 100 mg Tablets	**100 mg**	Oral	THREE times daily - 7am;1pm;10pm	Patients Own Supply	Yes
TIOTROPIUM 2.5 micrograms (SPIRIVA) aspimat	**5 microgram**	Inhalation	ONCE daily at 7am	Patients Own Supply	Yes

* Non-verified Orders Exist ***

Additional Medicines Information:

Medicines discontinued or modified during admission
(medicines that patient was recorded as admitted on only)

Drug	Discontinue/Modification reason

*** ***Warning*** - *accuracy of information in this section is dependent on details entered by users of the HEPMA system.****
*****Information here may be incomplete and is for guidance only.*****

Discharged by : DR RACHAEL ELLIS
Grade: Foundation Year 1

Dispensed by:
Date:

Checked by:

Confidential - Clinical Information

Department of Acute Medicine
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
01563 521133

www.nhsaaa.net

NHS Ayrshire & Arran

Stephen Galloway
28 Redburn Place
Irvine
Ayrshire
KA12 9BH

Our Ref:	DW/BF
Date Dictated:	24/05/2021
Date Typed:	27/05/2021
Enquiries to	Bernadette Finnie
Direct Line:	01563 826837
Ext. Number:	26837
Email:	bernadette.finnie@aapct.scot.nhs.uk

Dear Stephen Galloway,

STEPHEN GALLOWAY DOB: 14/06/1965 CHI No: 1406650854
28 REDBURN PLACE, IRVINE, AYRSHIRE, KA12 9BH

My colleague, Dr Smith arranged for you to have an outpatient endoscopy performed following your admission to hospital in December 2020. I have just received the formal report of this which shows that there is some mild inflammation within your stomach but no other significant abnormalities. I see that you are already on medication to suppress acid secretion in your stomach, Lansoprazole, and I don't think any further action is required.

I hope this letter finds you well.

Yours sincerely

Authorised on 31/05/2021 13:42:11 by David Wilkin.

Dr David Wilkin
Consultant in Acute Medicine
GMC 6075927

Dr TG Miller
Frew Terrace Surgery
9 Frew Terrace
Irvine
Ayrshire
KA12 9DY

INVESTING IN VOLUNTEERS

University Hospital Crosshouse,
Kilmarnock Road,
Kilmarnock,
KA2 0BE
Phone : 01563 521133

Immediate Discharge Letter & Prescription

NHS Ayrshire & Arran

To: Miller, Dr. TG,
9 FREW TERRACE,
IRVINE,
KA12 9DY

Re: STEPHEN GALLOWAY
28 REDBURN PLACE,IRVINE,AYRSHIRE,KA12 9BH

DOB: 14/06/1965
Hosp. No.: 1406650854
CHI No.: 1406650854

Date of Admission: 13/12/2020
Mode of Admission: Emergency Admission
Admission Reason: hallucinations
Discharge Date: 17/12/2020

Ward: XCAU AMBULATORY
Consultant: DR KATI CARROLL (Acute Medicine) Smith
Follow-up: Nil to add 616326

Primary Diagnosis: Alcohol withdrawal
?Upper GI bleed

Secondary Diagnoses: Alcohol excess *last updated 17/12/2020; 2:20 pm by DR LIAM TORRENS*

Investigations: Hb 126 *last updated 17/12/2020; 2:20 pm by DR LIAM TORRENS*

Clinical Progress: Stephen Galloway was admitted on 13/12/20, with hallucinations, insomnia, sweating and tremors. He had recently stopped drinking alcohol abruptly 5 days prior. He also reported passing black stool for previous 2 weeks.
On examination he was well, alert and tremulous with no evidence of delirium. Abdomen soft, non tender.

Investigations revealed a mild anaemia, with normal urea. He was managed with diazepam and pabrinex for alcohol withdrawal, and improved after a few days treatment. During his admission he passed dark brown stool with no evidence on melena.

Stephen was discharged home on 16/12/20 with advice to contact alcohol liaison nurse.

Yours sincerely
DR L TORRENS
CDF ACUTE MED *last updated 17/12/2020; 2:20 pm by DR LIAM TORRENS*

Hospital follow up: Outpatient OGD *last updated 17/12/2020; 2:20 pm by DR LIAM TORRENS*

Further patient/drug notes:

Allergy/Intolerance	Reaction
No Known Drug Allergies	

Allergy records are as recorded at time and date of printing

Drug	Dose	Route	Frequency	Days Supply	GP to continue
AMITRIPTYLINE 25 mg Tablets	**25 mg**	Oral	ONCE daily at 10pm	Patients Own Supply	Yes
CO-CODAMOL 15/500 Tablets	**2 Tablet**	Oral	FOUR times daily - 7am;1pm;6pm;10pm WHEN REQUIRED - FOR PAIN	Patients Own Supply	Yes
LANSOPRAZOLE 30 mg Capsules	**30 mg**	Oral	ONCE daily at 7am	Patients Own Supply	Yes
LAXIDO Sachets	**1 Sachet**	Oral	TWICE daily at 7am and 10pm	Patients Own Supply	Yes
SALBUTAMOL 100 micrograms (MDI) per metered dose	**200 microgram**	Inhalation	WHEN REQUIRED - FOR BREATHLESSNESS	Patients Own Supply	

Discharged by : DR LIAM TORRENS **Dispensed by:** **Checked by**
Grade: Clinical Development Fellow **Date:**

University Hospital Crosshouse,
Kilmarnock Road,
Kilmarnock,
KA2 0BE
Phone : 01563 521133

Immediate Discharge Letter & Prescription

NHS Ayrshire & Arran

Date :17/12/2020 @ 14:20:58

To: Miller, Dr. TG,
9 FREW TERRACE,
IRVINE,
KA12 9DY

Re: STEPHEN GALLOWAY
28 REDBURN PLACE,IRVINE,AYRSHIRE,KA12 9BH

DOB: 14/06/1965
Hosp. No.: 1406650854
CHI No.: 1406650854

TADALAFIL 5 mg Tablets	**5 mg**	Oral	ONCE daily at 7am	Patients Own Supply Yes
TIOTROPIUM 2.5 micrograms (SPIRIVA) Respimat	**5 microgram**	Inhalation	ONCE daily at 7am	Patients Own Supply Yes

*** Non-verified Orders Exist ***

Additional Medicines Information:

Medicines discontinued or modified during admission
(medicines that patient was recorded as admitted on only)

Drug	Discontinue/Modification reason
LAXIDO Sachets	Dose changed
THIAMINE 100 mg Tablets	Therapeutic Duplication

*** ***Warning*** - *accuracy of information in this section is dependent on details entered by users of the HEPMA system.* ***
*****Information here may be incomplete and is for guidance only.*****

Discharged by : DR LIAM TORRENS
Grade: Clinical Development Fellow
Dispensed by:
Date:
Checked by:

Originally Printed: 17/12/2020 @ 14:20 Revised: @

University Hospital Crosshouse,
Kilmarnock Road,
Kilmarnock,
KA2 0BE
Phone : 01563 521133

Immediate Discharge Letter & Prescription

NHS Ayrshire & Arran

Date :17/12/2020 @ 14:20:58

To: Miller, Dr. TG,
9 FREW TERRACE,
IRVINE,
KA12 9DY

Re: STEPHEN GALLOWAY
28 REDBURN PLACE,IRVINE,AYRSHIRE,KA12 9BH

DOB: 14/06/1965
Hosp. No.: 1406650854
CHI No.: 1406650854

Date of Admission: 13/12/2020
Mode of Admission: Emergency Admission
Admission Reason: hallucinations
Discharge Date: 17/12/2020

Ward: XCAU AMBULATORY
Consultant: DR KATI CARROLL (Acute Medicine)
Follow-up:

Primary Diagnosis: Alcohol withdrawal
?Upper GI bleed

Secondary Diagnoses: Alcohol excess *last updated 17/12/2020; 2:20 pm by DR LIAM TORRENS*

Investigations: Hb 126 *last updated 17/12/2020; 2:20 pm by DR LIAM TORRENS*

Clinical Progress:

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Yours sincerely
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CDF ACUTE MED *last updated 17/12/2020; 2:20 pm by DR LIAM TORRENS*

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LAXIDO Sachets	**1 Sachet**	Oral	TWICE daily at 7am and 10pm	Patients Own Supply	Yes
SALBUTAMOL 100 micrograms (MDI) per metered dose	**200 microgram**	Inhalation	WHEN REQUIRED - FOR BREATHLESSNESS	Patients Own Supply	Yes

Discharged by : DR LIAM TORRENS
Grade: Clinical Development Fellow
Dispensed by:
Date:
Checked by:

Originally Printed: 17/12/2020 @ 14:20 Revised: @

University Hospital Crosshouse,
Kilmarnock Road,
Kilmarnock,
KA2 0BE
Phone : 01563 521133

Immediate Discharge Letter & Prescription

NHS Ayrshire & Arran

Date :17/12/2020 @ 14:20:58

To: Miller, Dr. TG,
9 FREW TERRACE,
IRVINE,
KA12 9DY

Re: STEPHEN GALLOWAY
28 REDBURN PLACE,IRVINE,AYRSHIRE,KA12 9BH

DOB: 14/06/1965
Hosp. No.: 1406650854
CHI No.: 1406650854

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THIAMINE 100 mg Tablets	Therapeutic Duplication

*** ***Warning*** - *accuracy of information in this section is dependent on details entered by users of the HEPMA system.* ***
*****Information here may be incomplete and is for guidance only.*****

Discharged by : DR LIAM TORRENS
Grade: Clinical Development Fellow
Dispensed by:
Date:
Checked by:

Originally Printed: 17/12/2020 @ 14:20 Revised: @

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 1010194785534

REFERRAL LETTER

CHI:1406650854

MEDICAL IN CONFIDENCE

REFERRAL TO

ShoulderC8A2
AA Shoulder

Musculoskeletal Triage and Treatment
NHS Ayrshire & Arran

Ethnic Origin	(White) Scottish
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	29-Aug-2019
Date submitted	29-Aug-2019

PATIENT DETAILS

Surname	Galloway
Forename(s)	Stephen
Title	-
Sex	Male
Date of birth	14-Jun-1965
CHI no.	1406650854

Patient's address

28 Redburn Place
Irvine
KA12 9BH

Contact number(s)

Voice: 07468 337186

REGISTERED GP DETAILS

Name	Dr Duncan McNab		
GMC code	4507903	GP code	20265
Practice name	Frew Terrace Surgery (16883)		
Practice code	80698		

Practice address

9 Frew Terrace
Irvine

Contact number(s)

Voice: 01294 272326
Facsimile: 01294 312614

REFERRING PRACTITIONER DETAILS

Name	Dr. Garry Walker		
GMC code	3309300	GP code	24112
Practice name	Frew Terrace Surgery (80698)		
Practice code	80698		

Practice address

9 Frew Terrace
Irvine
Ayrshire
KA12 9DY

Contact number(s)

Voice: 01294 272326

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: see letter ks

Comment: Dear Colleague, Thank you for seeing this 54 year old man who has a 10 month history of pain affecting his right shoulder. He previously worked as a painter and decorator. He describes an audible click noise and this seems to centre around his AC joint. As well as this area he also has pain in is right upper lateral arm. He abducts about 90? although extension is better performed. Pain is keeping him awake at night. I would be grateful if he could have some physio intervention to assess and provide management for him. Yours sincerely

Examinations and Investigations

Height:	168	-
Weight(kg):	70	-
BMI:	24.8	-
Moderate smoker - 10-19 cigs/d :		29-Sep-2016
Moderate smoker - 10-19 cigs/d : denies excessive alcohol use - used to drink heavily		22-Mar-2016
Current smoker:		25-Feb-2016
Moderate smoker - 10-19 cigs/d:		28-Jan-2015
Smoker :		28-Jan-2015
Current smoker:		28-Jan-2015
Moderate smoker - 10-19 cigs/d:		09-Jan-2014
Current smoker:		09-Jan-2014

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Alcohol withdrawal syndrome	-	-	-	10-Apr-2019	10-Apr-2019
Shortness of breath symptom	-	-	attended A+E	09-Apr-2019	09-Apr-2019
Chronic obstructive pulmonary disease	-	-	-	25-Jan-2019	25-Jan-2019
Alcohol withdrawal syndrome	-	-	-	13-Aug-2018	13-Aug-2018
Erectile dysfunction	-	-	-	04-Apr-2014	04-Apr-2014
Anxiety with depression	-	-	-	22-Feb-2012	22-Feb-2012
Suicidal ideation	-	-	-	15-Dec-2011	15-Dec-2011
Erectile dysfunction	-	-	-	24-Jul-2008	24-Jul-2008
Balanitis	-	-	Recurrent	20-Jan-2005	20-Jan-2005
Chronic diarrhoea	-	-	-	16-Jan-2005	16-Jan-2005
Ganglion of joint	-	-	Right lateral mallelolus	08-Sep-2004	08-Sep-2004
O/E - Wound infected	-	-	Right ring finger. Laceration explored in theatre 5 days previously	16-May-2002	16-May-2002
In prison	-	-	Liberated 19/4/02	17-Apr-2002	17-Apr-2002

Suicide and selfinflicted injury caustic subst, excl poison	-	-	Deliberate ingestion of 50 mls disinfectant (methylated spirits)	21-Jul-2001	21-Jul-2001
Haematemesis	-	-	Admitted. Diazepam for withdrawal	11-Oct-1999	11-Oct-1999
Gastro-oesophageal reflux with oesophagitis	-	-	Gastric ulcer. Gastritis	11-Oct-1999	11-Oct-1999
[X]Self inflicted injury	-	-	Stab wound. Refused psychiatric referral	05-Apr-1997	05-Apr-1997
Suicide + selfinflicted poisoning by drug or medicine NOS	-	-	Paracetamol. Alcohol intoxication. Charged with drinking and driving. Abusive and aggressive. Irregular discharge	07-Jan-1996	07-Jan-1996
Closed fracture of mandible, angle of jaw	-	-	-	14-Nov-1987	14-Nov-1987

Past procedures

Description	Laterality	Modifier	Comments	Date performed	Recorded Date
EMG - Electromyography normal	-	-	-	02-Feb-2017	02-Feb-2017
Nerve conduction studies	-	-	Normal	02-Feb-2017	02-Feb-2017
Ultrasound of scrotum	-	-	Small hydrocele	18-Apr-2012	18-Apr-2012
Ultrasound of testes	-	-	Normal	21-Mar-2012	21-Mar-2012
Reduction of fracture of zygomatic bones (Left)	Left	-	-	07-Jul-2006	07-Jul-2006
Standard circumcision	-	-	-	22-Apr-2005	22-Apr-2005
Bilateral vasectomy for contraception	-	-	-	22-Apr-2005	22-Apr-2005
Endoscopy normal	-	-	-	10-Mar-2005	10-Mar-2005
Colonoscopy normal	-	-	-	10-Mar-2005	10-Mar-2005
CLO test for helicobacter pylori	-	-	Positive	25-Nov-1999	25-Nov-1999
Alcohol detoxification	-	-	Failed to keep 2 appointments so discharged.	25-Jul-1997	25-Jul-1997

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Salbutamol Cfc-free inhaler 100 micrograms/puff	0301011R0AAAPAP	1 INHALER	ONE TO TWO PUFFS TO BE INHALED AS REQUIRED FOR BREATHLESSNESS	-	25-Jan-2019	-	28-Aug-2019
Tadalafil Tablets 5 mg	-	28 TABLET	ONE TAB DAILY	-	20-Sep-2018	-	28-Aug-2019
Thiamine Hydrochloride Tablets 100 mg	0906026M0AAAGAG	84 TABLET	ONE TO BE TAKEN THREE TIMES A DAY	-	17-Aug-2018	-	05-Aug-2019
Lansoprazole Capsules (Gastro-Resistant) 30 mg	0103050L0AAAAAA	56 capsule	ONE TO BE TAKEN EACH DAY	-	21-Feb-2014	-	28-Aug-2019

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Seretide 250 Evohaler Cfc-free inhaler	-	1 inhaler	2 Puffs Twice daily	-	28-Aug-2019	0 Days	28-Aug-2019
Propranolol Hydrochloride Tablets 40 mg	0204000R0AAAJAJ	84 TABLET	ONE TO BE TAKEN THREE TIMES A DAY	-	28-Aug-2019	28 Days	28-Aug-2019
Co-Codamol 15/500 Tablets	-	100 tablet	ONE OR TWO TO BE TAKEN FOUR TIMES A DAY WHEN REQUIRED	-	28-Aug-2019	12 Days	28-Aug-2019

Clinical warnings

Smoking status

Alcohol consumption

Lifestyle risks

Exercise status: Not Known

Number per day
? (not known)

Units per day
? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

Social circumstances

Signature of referring doctor (or other professional) **Date**

Confidential - Clinical Information

Gastroenterology and Hepatology
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE

01563 521133
www.nhsaaa.net

NHS Ayrshire & Arran

Dr TG Miller
Frew Terrace Surgery
9 Frew Terrace
Irvine
Ayrshire
KA12 9DY

Our Ref:	AAS/CG
Hospital No:	
Clinic Date:	04/05/2019
Date Dictated:	04/05/2019
Date Typed:	05/06/2019
Enquiries to	Margaret Rowan
Direct Line:	01563 825127
Ext. Number:	25127
Email:	

Dear Dr Miller,

STEPHEN GALLOWAY DOB: 14/06/1965 CHI No: 1406650854
28 REDBURN PLACE, IRVINE, AYRSHIRE, KA12 9BH

Diagnosis: Alcohol induced mild liver damage in November

This gentleman has cut down his alcohol and that is reflected in his bloods which are better. His ultrasound was normal and there was no evidence of any cirrhosis. He is clinically well. I would therefore advise him not to drink alcohol excessively and hopefully he will listen to my advice but as there is no damage at present and his LFT's are normal I have discharged him back to your care but if there is any concern I would be more than happy to see him again.

MEDICAL

Yours sincerely

Authorised on 20/06/2019 14:54:51 by A A Shah.

Dr. A A Shah MD FRCPI. FRCP (Glasg)
Consultant Gastroenterologist
GMC: 4044611

INVESTING IN VOLUNTEERS

Confidential - Clinical Information

Gastroenterology and Hepatology
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
Tel: 01563 521133
Fax: 01563 827973
www.nhsaaa.net

NHS Ayrshire & Arran

Stephen Galloway
28 Redburn Place
Irvine
Ayrshire
KA12 9BH

Our Ref:	RW/MR/
Hospital No:	
Ref Date:	21/01/2019
Date Dictated:	24/02/2019
Date Typed:	13/03/2019
Enquiries to	Ms M Rowan
Direct Line:	01563 825127
Ext. Number:	25127
Email:	margaret.rowan@aaaht.scot.nhs.uk

Dear Mr Galloway,

STEPHEN GALLOWAY DOB: 14/06/1965 CHI No: 1406650854
28 REDBURN PLACE, IRVINE, AYRSHIRE, KA12 9BH

I hope you are doing well after your discharge from Crosshouse Hospital January 2019. I understand that you were given a new diagnosis of COPD (emphysema). As part of your care I have organised for you to have some outpatient breathing tests called Spirometry. The department will be in touch about these soon.

These tests are just to confirm the diagnosis that we are already treating you for. There is nothing to worry yourself about but it is probably important to have these done.

Kind regards,

Yours sincerely

Authorised on 26/03/2019 14:45:06 by Ryan Wereski.

Ryan Wereski
CT2 in General Medicine
GMC: 7474647

MEDICAL

INVESTING IN VOLUNTEERS

Confidential - Clinical Information

Gastroenterology and Hepatology
University Hospital Crosshouse
Kilmarnock Road
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KA2 0BE
Tel: 01563 521133
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NHS Ayrshire & Arran

Dr TG Miller
Frew Terrace Surgery
9 Frew Terrace
Irvine
Ayrshire
KA12 9DY

Our Ref: RW/MR
Hospital No:
Date Dictated: 24/02/2019
Date Typed: 13/03/2019
Enquiries to Ms M Rowan
Direct Line 01563 825127
Ext. Number 25127
Email margaret.rowan@aaaht.scot.nhs.uk

Dear Dr Miller,

STEPHEN GALLOWAY DOB: 14/06/1965 CHI No: 1406650854
28 REDBURN PLACE, IRVINE, AYRSHIRE, KA12 9BH

Date of admission: 21.01.19
Date of discharge: 23.01.19

Following Mr Galloway's discharge on 23rd January I have ordered a full lung function test for Mr Galloway on a routine. This will hopefully compliment the presumed diagnosis of chronic obstructive pulmonary disease. At the point of discharge we had simply given him a Salbutamol inhaler as required. We have advised him to be in contact with yourselves for escalation of this treatment as per your standard COPD protocols if required.

If there is any untowards abnormalities we will be in touch.

Yours sincerely

Authorised on 26/03/2019 14:45:35 by Ryan Wereski.

Ryan Wereski
CT2 in General Medicine
GMC: 7474647

MEDICAL

INVESTING IN VOLUNTEERS

University Hospital Crosshouse Kilmarnock Road Kilmarnock KA2 0BE Phone: 01563 521133	Immediate Discharge Letter & Prescription

To:	Re:
Frew Terrace Surgery 9 Frew Terrace Irvine Ayrshire KA12 9DY	STEPHEN GALLOWAY 28 REDBURN PLACE , , IRVINE , AYRSHIRE , KA12 9BH DOB: 14/06/1965 Hosp. No.: 1406650854 CHI No.: 1406650854

Date of Admission: 21/01/2019
Mode of Admission: Emergency
Admission Reason:
Discharge Date: 23/01/2019

Ward: WARD 3D - XH
Consultant: DR ALI TAHA (Gastroenterology)
Follow Up:

Diagnoses
Lower respiratory tract infection
New diagnosis COPD

( )

Secondary Diagnoses
Anxiety
Depression
Previous hypertension
Alcohol excess

DR REBECCA MCPARTLIN (23-JAN-2019 11:27)

Investigations
ECG: Sinus rhythm

DR REBECCA MCPARTLIN (23-JAN-2019 11:27)

Clinical Progress
Dear Doctor,
Stephen Galloway was admitted with a 1 week history of increasing shortness of breath with cough productive of yellow sputum. He was treated with oral antibiotics and steroids. He has to complete the course at home. He is now fit for discharge and could we please ask that his new diagnosis of COPD is follow-up in the community. Thank you

DR REBECCA MCPARTLIN (23-JAN-2019 11:27)

GP follow-up
Could we kindly ask that you check Mr Galloway's bloods in 1 week and follow-up his new diagnosis of COPD. Thank you for your continuing care.

DR REBECCA MCPARTLIN (23-JAN-2019 11:27)

Discharged by: DR REBECCA MCPARTLIN

Report generated on: 23/01/2019 20:00

University Hospital Crosshouse Kilmarnock Road Kilmarnock KA2 0BE Phone: 01563 521133	Immediate Discharge Letter & Prescription

To:	Re:
Frew Terrace Surgery 9 Frew Terrace Irvine Ayrshire KA12 9DY	STEPHEN GALLOWAY 28 REDBURN PLACE , , IRVINE , AYRSHIRE , KA12 9BH DOB: 14/06/1965 Hosp. No.: 1406650854 CHI No.: 1406650854

Allergy/Intolerance	Reaction
No Known Drug Allergies	

Allergy records are as recorded at time and date of printing.

Drug	Dose	Route	Frequency	Note	GP to continu	POD	Days Supply
AMOXICILLIN 500 mg Capsules	**500 mg**	Oral	THREE times daily - 7am;1pm;10pm		No	N	5
LANSOPRAZOLE 30 mg Capsules	**30 mg**	Oral	ONCE daily at 7am		Yes	Y	
PREDNISOLONE 5 mg Tablets	**40 mg**	Oral	ONCE daily at 7am		No	N	3
SALBUTAMOL 100 crograms (MDI) per metered dose	**200 microgram**	Inhalation	PRN FOR BREATHLESSNESS		Yes	Y	

Discharged by: DR REBECCA MCPARTLIN

Report generated on: 23/01/2019 20:00

University Hospital Crosshouse Kilmarnock Road Kilmarnock KA2 0BE Phone: 01563 521133	Immediate Discharge Letter & Prescription

To:	Re:
Frew Terrace Surgery 9 Frew Terrace Irvine Ayrshire KA12 9DY	STEPHEN GALLOWAY 28 REDBURN PLACE , , IRVINE , AYRSHIRE , KA12 9BH DOB: 14/06/1965 Hosp. No.: 1406650854 CHI No.: 1406650854

Additional Medicines Information:

Medicines discontinued or modified during admission (Medicines that patient was recorded as admitted on only)	
Drug	**Discontinued / Modified reason**
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Discharged by: DR REBECCA MCPARTLIN

Report generated on: 23/01/2019 20:00

Mental Health and Alcohol Liaison Referrals

Response to CAU and other wards will be within a 24 hour period of receiving referral. We will aim to respond on the same day however the ability to do so will be dependent upon the patient's progress, estimated discharge date and the Mental Health Liaison Services capacity and clinical priorities.

Referral For:

Alcohol Liaison ////☐

Name: Stephen Galloway CHI Number:1406650854
Address: 28 Redburn Place, Irvine. KA12 9BH

Ward/ Zone: AC/CAU

Consultant:Dr Manuel

Site: Crosshouse ☐
Date of Admission:04/11/2018 Date of Referral:05/11/2018

Estimated date/time of medical fitness for discharge home:07/11/2018

STATUS: Informal ☐

Detention Commenced (inc. time): Detention Expires:

Reason for Admission.Alcohol withdrawal and abdo pain

Reason for Referral.Assesment

Has the patient consented to the referral? Y ☐
If no, consider if the referral is still appropriate or necessary.

Relevant mental health history,Known alcohol withdrawal and seizures

Relevant alcohol/drug history (what, how much & when last used)
1 litre to 1 ½ litres spirits daily. Last drank yesterday

AAMAWS Score, if alcohol withdrawals suspected- on AAMAWS AND REGULAR DIAZEPAM 0-1 score

Relevant Medical History (Previous DTs/seizures)
Alcohol withdrawal/seizures

Current treatment and estimated time of completion: Pabrinex and regular/ plus PRN diazepam

Pending investigations:Nil, monitoring BP as raised

Investigations carried out & results. (MSSU / bloods / drug screen done as appropriate? **Ensure magnesium level obtained for acute alcohol presentations**)

Awaiting urinalysis, for further bloods in mane

Name of Referrer:Karen Muller Contact details: Ext 27467

Send to: Clinical_MentalHealth_LiaisonPsychiatry_A&A@aapct.scot.nhs.uk

Confidential - Clinical Information

Infectious Disease Department
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
01563 521133
01563 825248
www.nhsaaa.net

NHS Ayrshire & Arran

Dr TG Miller
Frew Terrace Surgery
9 Frew Terrace
Irvine
Ayrshire
KA12 9DY

Our Ref:	ES/FE/
Hospital No:	
Ref Date:	15/10/2018
Date Dictated:	15/10/2018
Date Typed:	20/10/2018
Enquiries to	Fiona Elliott
Direct Line:	01563 827970
Ext. Number:	27970
Email:	fiona.elliott@aapct.scot.nhs.uk

Dear Dr Miller,

STEPHEN GALLOWAY DOB: 14/06/1965 CHI No: 1406650854
28 REDBURN PLACE, IRVINE, AYRSHIRE, KA12 9BH

Mr Galloway was admitted to University Hospital Crosshouse with alcohol withdrawal. He was treated with Pabrinex and Diazepam as per the GMAWS tool. He remained well on Diazepam and completed the reducing dose regimen.

He was tested for blood borne viruses and his screen was negative.

He has been discharged with follow up with alcohol liaison. There is no hospital follow up.

Kind regards

Yours sincerely

Authorised on 27/11/2018 16:17:17 by Eleanor Singer.

Eleanor Singer
CT2 in Infectious Diseases
GMC: 7461257

MEDICAL

INVESTING IN VOLUNTEERS

Emailed PO:
Clinical - specialty - gastroenterology@
aapct.scot.nhs.uk

CAU

Crosshouse Hospital

09/11/2018

Referral to Gastroenterology

Request for outpatient review

Name: Stephen Galloway

CHI: 1406650854

Address: 28 Redburn Place, Irvine KA12 9BH

Route as appointment as
New
6/11

Dear Doctor

Background: alcohol excess

Mr Galloway presented to CAU on 04/11/2018 with abdominal pain, vomiting and feeling shaky and sweaty. He drinks about 1-1.5 L of spirit every day.

Treated for alcohol withdrawal with pabrinex and GMAWS.

Blood tests showed raised ALT 210, AST 107. Bilirubin <0.3

Liver screen done and there was mild raise of ferritin 376, ESR 17. Low IgM 0.43.

Outpatient ultrasound requested.

The case was discussed with Dr Shah, could be related to alcohol drinking but need to exclude other causes. He asked to refer him to the clinic.

We would be grateful for your kind opinion and review for this patient.

Regards

Abdullah Al-Dallaali

Specialty doctor in acute medicine

✓ on system
pending appt
as at 10/12/18
RM

TRANSMISSION VERIFICATION REPORT

TIME : 05/12/2018 12:09
NAME :
FAX :
TEL :
SER.# : E71277M7J534821

DATE,TIME	05/12 12:09
FAX NO./NAME	27973
DURATION	00:00:23
PAGE(S)	02
RESULT	OK
MODE	STANDARD ECM

Fax Cover Sheet

05.12.18

URGENT

F.A.O. Margaret Rowan, Gastroenterology Secretary, Level 3 East

From Alison Houston, CAU office, Crosshouse

Margaret, this was emailed in November, but no appointment on system.

Thanks for your help

Alison Ext 26838

Emailed to:
Clinical - specialty - gastroenterology@aapct.scot.nhs.uk

CAU

Crosshouse Hospital

09/11/2018

5/12/18
No appt on system
Faxed to Margaret Rowan

Referral to Gastroenterology

Request for outpatient review

Name: Stephen Galloway

CHI: 1406650854

Address: 28 Redburn Place, Irvine KA12 9BH

Dear Doctor

Background: alcohol excess

Mr Galloway presented to CAU on 04/11/2018 with abdominal pain, vomiting and feeling shaky and sweaty. He drinks about 1-1.5 L of spirit every day.

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The case was discussed with Dr Shah, could be related to alcohol drinking but need to exclude other causes. He asked to refer him to the clinic.

We would be grateful for your kind opinion and review for this patient.

Regards

Abdullah Al-Dallaali

Specialty doctor in acute medicine

Mental Health Services

Psychiatric Liaison Service
33 Lister Street
Crosshouse Hospital
KILMARNOCK
KA2 0BE

01563 521133

NHS
Ayrshire & Arran

Clinical in Confidence

Dr M ~~Manuel~~ Smith
Consultant Physician
Crosshouse Hospital

Date Assessed: 9th November 2018
Date Typed: 21st November 2018
Our Ref: MF/MAP
CHI: 1406650854
Enquiries to: Ann Pride, Secretary
Direct Line: 01292 617255

Dear Dr ~~Manuel~~ Smith

RE: STEPHEN GALLOWAY DOB: 14/06/1965 CHI: 1406650854

The above named patient was referred to the Alcohol Liaison Service during his recent admission to Crosshouse Hospital.

I have enclosed, for your information, an Activity Record and please do not hesitate to contact me should you wish to discuss this further.

Yours sincerely

Margaret Frew

Margaret Frew
Alcohol Liaison Nurse

Enc

cc Dr Miller, Frew Terrace Surgery, Irvine.

INVESTING IN VOLUNTEERS

www.nhsaaa.net

Service User Copy Printed 21/11/2018 by Ann Pride (Personal secretary (Mental Health Services))

carepartner

Galloway, Stephen (Mr)

Date of Birth 14-Jun-1965 (53y)	Gender Male	CHI Number 1406650854

Referral Contact Record - MH Liaison Service

Status Closed	Centre of Care Alcohol Liaison Service	Location Hospital (including Day Hospital)

Date of Activity 9th Nov 2018 at 11:32 by Ms Margaret Frew (Liaison) (Charge Nurse (Mental Health))

Contact details

Date referral received
07/11/2017

Time referral received
Time 12.00

Date assessment commenced
07/11/2018

Time assessment commenced
Time 17.00

Time difference from Referral to Assessment
5.00 hours

Locality
North Ayrshire

Referral type
Telephone consultation

Presenting problems
Alcohol Misuse

Presentation via police?
No

Current contact with Mental Health Services?
No

Legal status on admission
Informal

Adults with Incapacity Act

Adult Support & Protection referral complete
No

Assessment details

Duration of patient/client contact
30 mins

Duration of patient/client related activity
30 mins

Assessment completed?
Yes

Interventions

Alcohol Brief Interventions
Yes

Distress Brief Interventions
Yes

Service User Copy Printed 21/11/2018 by Ann Pride (Personal secretary (Mental Health Services))

carepartner

Galloway, Stephen (Mr)

Date of Birth 14-Jun-1965 (53y) | **Gender** Male | **CHI Number** 1406650854

Psycho education
Yes

Signposting
Yes

Post Diagnostic Support
No

Outcome

Assessment outcome
Discharge

Discharge destination (if applicable)
NA

Summary of contact

Summary of contact
PLAN OF CARE AS DISCUSSED AND AGREED WITH STEPHEN

ABI completed. ALN will send Stephen out an alcohol information pack and will refer him to NADARS for support to maintain abstinence from alcohol; 1:1 psychosocial support and for assessment for the rehab programme at ward 5. Stephen was orientated to time, place and person with no evidence of any decision impairing condition. He reported his mood is a low and self rated it at 2/10 on a scale of 1-10; 10 being good. He reported previous suicidal thoughts but nil currently.

Stephen is keen for information on Disulfiram and Acamprosate which the ALN will send to him. He can then discuss this medication with his GP.

Discharged from the ALS.

University Hospital Crosshouse Kilmarnock Road Kilmarnock KA2 0BE Phone: 01563 521133	**Immediate Discharge Letter** **&** **Prescription**	NHS Ayrshire & Arran

To:	Re:
Frew Terrace Surgery 9 Frew Terrace Irvine Ayrshire KA12 9DY	STEPHEN GALLOWAY 28 REDBURN PLACE , , IRVINE , AYRSHIRE , KA12 9BH DOB: 14/06/1965 Hosp. No.: 1406650854 CHI No.: 1406650854

Date of Admission: 04/11/2018
Mode of Admission: Emergency
Admission Reason:
Discharge Date: 07/11/2018

Ward: XCAU RAPID ASSE
Consultant: DR MAHANTH MANUEL (Acute Medicine)
Follow Up:

Acute Medicine Department
NHS Ayrshire & Arran, Crosshouse Hospital, Kilmarnock, KA2 0BE
This IDL to be considered as final discharge letter
Signature/Stamp:
Date: 22/11

Diagnoses Alcohol withdrawal

()

Secondary Diagnoses Alcohol excess

DR ABDULLAH AL-DALLAALI (07-NOV-2018 12:40)

Investigations
Deranged LFT.
Liver screen done and results pending.
Outpatient USS abdomen requested

DR ABDULLAH AL-DALLAALI (07-NOV-2018 12:40)

Clinical Progress
Presented with lower abdominal pain, and feeling sweatand shaky.
He usually drinks 1-1.5 L of spirit/day.
Treated with pabrinex and Diazepam. He didn't tolerate diazepam very well as it makes him dizzy.
Pabrinex treatment completed and switched back to thiamine.
The alcohol liaison team will contact him later for advice.

DR ABDULLAH AL-DALLAALI (07-NOV-2018 12:40)

Hospital follow up To return to RAA on 09/11/18 to check LFT.

DR ABDULLAH AL-DALLAALI (07-NOV-2018 12:40)

Allergy/Intolerance	Reaction
No Known Drug Allergies	

Allergy records are as recorded at time and date of printing.

Discharged by: DR ABDULLAH AL-DALLAALI

Report generated on: 07/11/2018 20:00

University Hospital Crosshouse Kilmarnock Road Kilmarnock KA2 0BE Phone: 01563 521133	Immediate Discharge Letter & Prescription	NHS Ayrshire & Arran

To:	Frew Terrace Surgery 9 Frew Terrace Irvine Ayrshire KA12 9DY	Re:	STEPHEN GALLOWAY 28 REDBURN PLACE , IRVINE , AYRSHIRE , KA12 9BH DOB: 14/06/1965 Hosp. No.: 1406650854 CHI No.: 1406650854

Drug	Dose	Route	Frequency	Note	GP to continue	POD	Days Supply
LANSOPRAZOLE 30 mg Capsules	**30 mg**	Oral	ONCE daily at 7am		Yes	Y	
TADALAFIL 5 mg Tablets	**5 mg**	Oral	ONCE daily at 7am		Yes	Y	
THIAMINE 100 mg Tablets	**100 mg**	Oral	THREE times daily - 7am;1pm;10pm		Yes	Y	

Additional Medicines Information:

Medicines discontinued or modified during admission (Medicines that patient was recorded as admitted on only)	
Drug	**Discontinued / Modified reason**
**** Warning - accuracy of information in this section is dependent on details entered by users of the HEPMA system.**** *****Information here may be incomplete and is for guidance only.*****	

Discharged by: DR ABDULLAH AL-DALLAALI

Report generated on: 07/11/2018 20:00

University Hospital Crosshouse Kilmarnock Road Kilmarnock KA2 0BE Phone: 01563 521133	Immediate Discharge Letter & Prescription	NHS Ayrshire & Arran

To:	Frew Terrace Surgery 9 Frew Terrace Irvine Ayrshire KA12 9DY	Re:	STEPHEN GALLOWAY 28 REDBURN PLACE , IRVINE , AYRSHIRE , KA12 9BH DOB: 14/06/1965 Hosp. No.: 1406650854 CHI No.: 1406650854

Date of Admission: 13/08/2018
Mode of Admission: Emergency
Admission Reason:
Discharge Date: 16/08/2018

Ward: WARD 5B - XH
Consultant: DR JOSE FERNANDEZ-MONTERO (General Medicine)
Follow Up:

Diagnoses Alcohol withdrawal
( )

Secondary Diagnoses Alcohol dependence
DR LEWIS MARSHALL (16-AUG-2018 14:48)

Clinical Progress Dear Doctor,
Mr Galloway was admitted with acute alcohol withdrawal. He was managed with IV pabrinex and a reducing course of diazepam. He is now clinically improved and suitable for discharge home.
Yours sincerely,
DR LEWIS MARSHALL (16-AUG-2018 14:48)

Hospital follow up Hepatitis serology sent (due to tattoos), result to follow.
DR LEWIS MARSHALL (16-AUG-2018 14:48)

Allergy/Intolerance	Reaction
No Known Drug Allergies	

Allergy records are as recorded at time and date of printing.

Discharged by: DR LEWIS MARSHALL

Report generated on: 16/08/2018 20:00

University Hospital Crosshouse Kilmarnock Road Kilmarnock KA2 0BE Phone: 01563 521133	Immediate Discharge Letter & Prescription	NHS Ayrshire & Arran

To:	Re:
Frew Terrace Surgery 9 Frew Terrace Irvine Ayrshire KA12 9DY	STEPHEN GALLOWAY 28 REDBURN PLACE , IRVINE , AYRSHIRE , KA12 9BH DOB: 14/06/1965 Hosp. No.: 1406650854 CHI No.: 1406650854

Drug	Dose	Route	Frequency	Note	GP to continu	PRN	Days Su
LANSOPRAZOLE 30 mg Capsules	**30 mg**	Oral	ONCE daily at 7am		Yes	N	28
THIAMINE 100 mg Tablets	**100 mg**	Oral	THREE times daily - 7am;1pm;10pm		Yes	N	28

Additional Medicines Information:

Medicines discontinued or modified during admission (Medicines that patient was recorded as admitted on only)	
Drug	**Discontinued / Modified reason**
**** Warning - accuracy of information in this section is dependent on details entered by users of the HEPMA system.*** ****Information here may be incomplete and is for guidance only.*****	

Discharged by: DR LEWIS MARSHALL

Report generated on: 16/08/2018 20:00

Confidential - Clinical Information

Neurology Department
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
Tel: 01563 521133
Fax: 01563 825171
www.nhsaaa.net

NHS Ayrshire & Arran

Dr P Kerr
Frew Terrace Surgery
9 Frew Terrace
Irvine
Ayrshire
KA12 9DY

Our Ref:	GK/SS/
Ref Date:	02/11/2017
Date Dictated:	02/11/2017
Date Typed:	02/11/2017
Enquiries to	Neurology Secretary
Direct Line:	01563 827178
Ext. Number:	27178
Email:	Stacy.Smith@aapct.scot.nhs.uk

Dear Dr Kerr,

STEPHEN GALLOWAY DOB: 14/06/1965 CHI No: 1406650854
28 REDBURN PLACE, IRVINE, AYRSHIRE, KA12 9BH

I reviewed the patient in the middle of July for a year long history of left-sided sensory symptoms. His neurological condition, MRI of cervical spine and brachial plexus as well as nerve conduction studies were unremarkable; I am referring to my clinical letter.

I booked the patient for a CT head to rule out intracranial changes. The study was performed on the 26th of October and they report on no specific change possibly representing early small vessel disease. They found no significant interval change sicne the previous CT done in 2016.
I suppose the result is reassuring.There is no clinical, radiological or neurophysiological evidence of an ongoing neurological condition so the symptoms remain unexplained from an organic neurological point of view. I am referring the patient back to your care.

Yours sincerely

Authorised on 04/11/2017 14:39:36 by Gabor Kiss.

Dr Gabor Kiss
Locum Consultant Neurologist
GMC Number 7421239

INVESTING IN VOLUNTEERS

Confidential - Clinical Information

Infectious Disease Department
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
01563 521133
01563 825248
www.nhsaaa.net

NHS Ayrshire & Arran

Dr TG Miller
Frew Terrace Surgery
9 Frew Terrace
Irvine
Ayrshire
KA12 9DY

Our Ref: ES/FE/
Hospital No:
Ref Date: 15/10/2018
Date Dictated: 15/10/2018
Date Typed: 20/10/2018
Enquiries to Fiona Elliott
Direct Line: 01563 827970
Ext. Number: 27970
Email: fiona.elliott@aapct.scot.nhs.uk

Dear Dr Miller,

STEPHEN GALLOWAY DOB: 14/06/1965 CHI No: 1406650854
28 REDBURN PLACE, IRVINE, AYRSHIRE, KA12 9BH

Mr Galloway was admitted to University Hospital Crosshouse with alcohol withdrawal. He was treated with Pabrinex and Diazepam as per the GMAWS tool. He remained well on Diazepam and completed the reducing dose regimen.

He was tested for blood borne viruses and his screen was negative.

He has been discharged with follow up with alcohol liaison. There is no hospital follow up.

Kind regards

Yours sincerely

Authorised on 27/11/2018 16:17:17 by Eleanor Singer.

Eleanor Singer
CT2 in Infectious Diseases
GMC: 7461257

INVESTING IN VOLUNTEERS

Neurology Department
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
01563 521133
01563 825171
www.nhsaaa.net

NHS Ayrshire & Arran

Confidential - Clinical Information

Dr P Kerr
Frew Terrace Surgery
9 Frew Terrace
Irvine
Ayrshire
KA12 9DY.

Our Ref: GK/SS
Clinic Date: 18/07/2017
Date Dictated: 18/07/2017
Date Typed: 19/07/2017
Enquiries to Neurology Secretary
Direct Line: 01563 827178
Ext. Number: 27178
Email: Stacy.Smith@aapct.scot.nhs.uk

Dear Dr Kerr,

STEPHEN GALLOWAY DOB: 14/06/1965 CHI No: 1406650854
28 REDBURN PLACE, IRVINE, AYRSHIRE, KA12 9BH

Thank you very much for referring the gentleman named above to our Neurology clinic today. His medical history is unremarkable except anxiety, depression and bad smoking habits. He is not on any medication at the moment.

Based on the patient's recollection, his symptoms started approximately one year ago. He developed a sudden onset pain in his neck and numbness of his *whole* body on the left side. He was admitted to the Crosshouse Hospital. According to the discharge letter, the story is a little bit different as the patient was admitted with left arm paresthesia and pain. His neurological examination was normal. An MRI of cervical spine and brachial plexus as well as nerve conduction studies of the left upper limb turned out to be normal.
The patient informs me his leg numbness stopped after a day, but he has still been experiencing permanent left upper limb tingling and numbness. There is no weakness or clumsiness and he has not noticed any change of his sensory symptoms involving the left upper limb.

Neurological examination: normal cranial nerves, normal muscle power and tone, normal reflexes, no Babinski sign, normal coordination, no consistent sensory deficit.

The patient's neurological condition is entirely normal.

Based on the discrepancy between the patient's recollection and his discharge letter from Crosshouse Hospital, the patient claiming his symptoms started with left-sided symptoms involving both upper and lower limbs as well, I wonder if he could have had a minor stroke. In order to find out intracranial changes I am booking the patient for a CT head. Therapy wise to reduce chronic pain I suggest he can try Pregabalin. He should start with 50mg once daily in the evening and increase the dose by 50mg steps, slowly and gradually according to tolerance and clinical response, and the target dose can be as high as 150mg twice daily.

Yours sincerely

Authorised on 20/07/2017 11:44:26 by Gabor Kiss.

INVESTING IN VOLUNTEERS

Dr Gabor Kiss
Locum Consultant Neurologist
GMC Number 7421239

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?	Unique Care Pathway Number: 101013480146P **REFERRAL LETTER** MEDICAL IN CONFIDENCE	CHI:1406650854

REFERRAL TO

NeurologyAH
AA Gen Ref - PMH Med & High

University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
Ayrshire
KA2 0BE

Ethnic Origin	(White) Scottish
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	20-Apr-2017
Date submitted	24-Apr-2017

PATIENT DETAILS

Surname	Galloway
Forename(s)	Stephen
Title	-
Sex	Male
Date of birth	14-Jun-1965
CHI no.	1406650854

Patient's address

28 Redburn Place
Irvine
KA12 9BH

Contact number(s)

Voice: 07468 337186

REGISTERED GP DETAILS

Name	Dr Duncan McNab		
GMC code	4507903	GP code	20265
Practice name	Frew Terrace Surgery (16883)		
Practice code	80698		

Practice address

9 Frew Terrace
Irvine

Contact number(s)

Voice: 01294 272326
Facsimile: 01294 312614

REFERRING PRACTITIONER DETAILS

Name	Dr L Peng		
GMC code	0000000	GP code	-
Practice name	Frew Terrace Surgery		
Practice code	80698		

Practice address

Frew Terrace
Irvine
KA12 9DY

Contact number(s)

-

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: see letter ks

Comment: Dear Colleague, Many thanks for seeing this 51 year old painter and decorator who has a one and a half year history of pain down his left arm with paraesthesia in his left hand. He presented to A+E in August 2016 with these symptoms and was admitted to CAU for further investigation. MRI scan of the cervical spine showed mild degenerative change at C5/6 and C6/7. Nerve conduction studies were normal in the upper limb. The pain seems to radiate from the left side of his neck down to the lateral aspect of his elbow. Motor control is not affected. I would be grateful for your assessment. Yours sincerely

Examinations and Investigations

Height:	168	-
Weight(kg):	70	-
BMI:	24.8	-
Moderate smoker - 10-19 cigs/d :		29-Sep-2016
Moderate smoker - 10-19 cigs/d : denies excessive alcohol use - used to drink heavily		22-Mar-2016
Current smoker:		25-Feb-2016
Moderate smoker - 10-19 cigs/d:		28-Jan-2015
Smoker :		28-Jan-2015
Current smoker:		28-Jan-2015
Moderate smoker - 10-19 cigs/d:		09-Jan-2014
Current smoker:		09-Jan-2014

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Arm pain	-	-	-	20-Apr-2017	20-Apr-2017
Erectile dysfunction	-	-	-	04-Apr-2014	04-Apr-2014
Anxiety with depression	-	-	-	22-Feb-2012	22-Feb-2012
Suicidal ideation	-	-	-	15-Dec-2011	15-Dec-2011
Erectile dysfunction	-	-	-	24-Jul-2008	24-Jul-2008
Balanitis	-	-	Recurrent	20-Jan-2005	20-Jan-2005
Chronic diarrhoea	-	-	-	16-Jan-2005	16-Jan-2005
Ganglion of joint	-	-	Right lateral mallelolus	08-Sep-2004	08-Sep-2004
O/E - Wound infected	-	-	Right ring finger. Laceration explored in theatre 5 days previously	16-May-2002	16-May-2002
In prison	-	-	Liberated 19/4/02	17-Apr-2002	17-Apr-2002
Suicide and selfinflicted injury caustic subst, excl poison	-	-	Deliberate ingestion of 50 mls disinfectant (methylated spirits)	21-Jul-2001	21-Jul-2001
Gastro-oesophageal reflux with oesophagitis	-	-	Gastric ulcer. Gastritis	11-Oct-1999	11-Oct-1999
Haematemesis	-	-	Admitted. Diazepam for withdrawal	11-Oct-1999	11-Oct-1999
[X]Self inflicted injury	-	-	Stab wound. Refused psychiatric referral	05-Apr-1997	05-Apr-1997
	-	-		07-Jan-1996	

Suicide + self-inflicted poisoning by drug or medicine NOS			Paracetamol. Alcohol intoxication. Charged with drinking and driving. Abusive and aggressive. Irregular discharge		07-Jan-1996
Closed fracture of mandible, angle of jaw	-	-	-	14-Nov-1987	14-Nov-1987

Past procedures

Description	Laterality	Modifier	Comments	Date performed	Recorded Date
EMG - Electromyography normal	-	-	-	02-Feb-2017	02-Feb-2017
Nerve conduction studies	-	-	Normal	02-Feb-2017	02-Feb-2017
Ultrasound of scrotum	-	-	Small hydrocele	18-Apr-2012	18-Apr-2012
Ultrasound of testes	-	-	Normal	21-Mar-2012	21-Mar-2012
Reduction of fracture of zygomatic bones (Left)	Left	-	-	07-Jul-2006	07-Jul-2006
Bilateral vasectomy for contraception	-	-	-	22-Apr-2005	22-Apr-2005
Standard circumcision	-	-	-	22-Apr-2005	22-Apr-2005
Endoscopy normal	-	-	-	10-Mar-2005	10-Mar-2005
Colonoscopy normal	-	-	-	10-Mar-2005	10-Mar-2005
CLO test for helicobacter pylori	-	-	Positive	25-Nov-1999	25-Nov-1999
Alcohol detoxification	-	-	Failed to keep 2 appointments so discharged.	25-Jul-1997	25-Jul-1997

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Amitriptyline Hydrochloride Tablets 10 mg	0403010B0AAAGAG	14 tablet	ONE TO BE TAKEN AT NIGHT	-	29-Sep-2016	-	07-Oct-2016
Lansoprazole Capsules (Gastro-Resistant) 30 mg	0103050L0AAAAAA	56 capsule	ONE TO BE TAKEN EACH DAY	-	21-Feb-2014	-	09-Dec-2016
Tadalafil Tablets 5 mg	-	8 TABLET	TO BE TAKEN AS DIRECTED	-	14-Jan-2014	-	19-Apr-2017

Recent medication (Any medication issued within last 90 days not shown above)

No recent medications recorded

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status	Alcohol consumption
Number per day ? (not known)	Units per day ? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

Social circumstances

Signature of referring doctor (or other professional) **Date**

Confidential - Clinical Information

Department of Acute Medicine
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
01563 826839

www.nhsaaa.net

NHS Ayrshire & Arran

Dr A Sharma
Frew Terrace Surgery
9 Frew Terrace
Irvine
Ayrshire
KA12 9DY

Our Ref:	MM/JS/
Date Dictated:	02/02/2017
Date Typed:	03/02/2017
Enquiries to	Joanne Shaw
Direct Line:	01563 826839
Ext. Number:	26839
Email:	joanne.shaw@aapct.scot.nhs.uk

Dear Dr Sharma,

STEPHEN GALLOWAY DOB: 14/06/1965 CHI No: 1406650854
28 REDBURN PLACE, IRVINE, AYRSHIRE, KA12 9BH

The nerve conduction studies are normal in the upper limb. EMG studies from C7 muscle on the left side are unremarkable. There were no helpful localising abnormalities.

As I mentioned in my previous letter, this could all be related to his position of the neck and some degenerative changes in the C5 to C7 spine. If he has any ongoing symptoms please refer him to Neurology.

Yours sincerely

Authorised on 03/02/2017 17:13:35 by Mahanth Manuel.

Dr Mahanth Manuel
Consultant in Acute Medicine
GMC: 6041033

MEDICAL

INVESTING IN VOLUNTEERS

Confidential - Clinical Information

Combined Assessment Unit
Department of Acute Medicine
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
01563 826839

www.nhsaaa.net

NHS Ayrshire & Arran

Dr A Sharma
Frew Terrace Surgery
9 Frew Terrace
Irvine
Ayrshire
KA12 9DY

Our Ref:	MM/JS/
Hospital No:	
Ref Date:	15/09/2016
Date Dictated:	04/10/2016
Date Typed:	05/10/2016
Enquiries to	Joanne Shaw
Direct Line:	01563 826839
Ext. Number:	26839
Email:	joanne.shaw@aapct.scot.nhs.uk

Dear Dr Sharma,

STEPHEN GALLOWAY DOB: 14/06/1965 CHI No: 1406650854
28 REDBURN PLACE, IRVINE, AYRSHIRE, KA12 9BH

The MRI of the cervical spine and brachial plexus shows no evidence of any brachial plexus injury or soft tissue injury. There was mild degenerative change at C5/C6 and C6/C7. There is a posterior disc osteophyte at C5/C6 but no compromising the exiting nerve or the cord.

No further action is needed and his symptoms may be due to position related.

Yours sincerely

Authorised on 06/10/2016 14:27:02 by Mahanth Manuel.

Dr Mahanth Manuel
Consultant in Acute Medicine
GMC: 6041033

INVESTING IN VOLUNTEERS

MEDICAL

Confidential - Clinical Information

Combined Assessment Unit
Department of Acute Medicine
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
01563 826839

www.nhsaaa.net

NHS Ayrshire & Arran

PRIVATE & CONFIDENTIAL
Stephen Galloway
28 Redburn Place
Irvine
Ayrshire
KA12 9BH

Our Ref:	MM/JS/
Hospital No:	
CHI:	1406650854
Date Dictated:	22/09/2016
Date Typed:	22/09/2016
Enquiries to	Joanne Shaw
Direct Line:	01563 826839
Ext. Number:	26839
Email:	joanne.shaw@aapct.scot.nhs.uk

Dear Mr Galloway,

I received information from the Cardiac Physiology Department that you did not turn up for your appointment for the treadmill test.

We are not going to send any further appointments and if you have any ongoing concerns about your health please see your General Practitioner.

Yours sincerely

Authorised on 29/09/2016 10:31:03 by Mahanth Manuel.

Dr Mahanth Manuel
Consultant in Acute Medicine
GMC: 6041033

Dr A Sharma
Frew Terrace Surgery
9 Frew Terrace
Irvine
Ayrshire
KA12 9DY

MEDICAL

INVESTING IN VOLUNTEERS

Shaw, Joanne

From: Kennedy, Denise
Sent: 20 September 2016 08:41
To: Shaw, Joanne; McSeveney, Julie
Subject: Dna

DNA ETT on 19/9/16

Hi Joanne/Julie

FYI. Pt dna no further apt made.

Outpatient Exercise Tolerance ECG - Internet Explorer

CHI: 1406650854 Name: Stephen Galloway Gender: Male DOB: 14/06/1965 Age: 51 Years Pl

Request Details

Outpatient Exercise Tolerance ECG

Test Visit No	3906643
Status	In Progress
Receiving Location	Crosshouse Hospital Clinical Pl
Priority	Normal
Start Date	06/09/2016
Start Time	12:07
Requested By	Patrick James Anstey
Responsible Clinician	Dr David Wilkin
Cancel Reason	
Patient Location when Ordered	CAU XH Inpatients

Questions and Answers

Method of Transport - ETT **Walking**

Does the patient have any physical limitations? **No**

Clinical Questions and Answers

Clinical Indications: What clinical ques exam answer? Include any alternative requirements **Recurrent left arm pa pain intermittently for 4-5 month motor control. Previously referre angina, defaulted previous apt, pl as OP**

Relevant Past Medical History? **Nil car GORD, Jaw fracture, traumatic hea**

Is the patients resting B.P is less than **Yes**

Is there a clinically significant cardiac

Audit Trail

Alert Messages Alert Messages

Processing Notes

Scanned Documents

Annotate

Denise Kennedy
ECG Department
Crosshouse Hospital
EXT 27200

University Hospital Crosshouse,
Kilmarnock Road, Kilmarnock,
KA2 0BE
Phone: 01563 521133

Immediate Discharge Letter & Prescription

Processed by Pharmacy

NHS Ayrshire & Arran

To: Sharma, Dr. A,
9 FREW TERRACE,
IRVINE,
KA12 9DY

Re: STEPHEN GALLOWAY
28 REDBURN PLACE,IRVINE,AYRSHIRE,KA12 9BH

DOB: 14/06/1965
Hosp. No.: 1406650854
CHI No.: 1406650854

Date of Admission: 24/08/2016
Mode of Admission: Emergency Admission
Admission Reason: neck and shoulder pain
Discharge Date: 25/08/2016

Ward: XCAU INPATIENT
Consultant: DR DAVID WILKIN (Acute Medicine)
Follow-up:

Primary Diagnosis: cervical nerve root compression/brachial plexus traction secondary to his job

Secondary Diagnoses: RTA last year - multiple head injuries, no memory of event, self-discharged
Alcohol excess - weekend binges *last updated 25/08/2016;10:53 am by DR FATIMA CHAUDHRY*

vestigations: ECG - sinus rhythm, high take-off V2-3
Bloods - Trop negative, *last updated 25/08/2016;10:59 am by DR FATIMA CHAUDHRY*

Clinical Progress: This 51year old gentleman who works as a painter/decorator presented with left arm paraesthesia and pain on movement of left arm radiating along C6/7 distribution. He has had recurrent paraesthesia and pain intermittently for the past 4-5 months. Denies any loss of motor control; denies chest pain on this presentation but defaulted in recent months from ETT for exertional angina. No systemic cardioresp symptoms today.
Alcohol excess - suffers mild withdrawal features, no previous seizure activity.
Examination - normal neurologically, chest clear

Fit for discharge; started on Amitriptyline 10mg at night for pain. *last updated 25/08/2016;10:59 am by DR FATIMA CHAUDHRY*

Hospital follow up: outpatient MRI requested
nerve conduction studies
outpatient ETT as defaulted previous appt. *last updated 25/08/2016;10:59 am by DR FATIMA CHAUDHRY*

Pharmacy: Amitriptyline 10mg at night for pain *last updated 25/08/2016;10:10 am by DR FATIMA CHAUDHRY*

ther patient/drug notes: *Patient Note* - Validated by J.Crosbie 25.8.16 11.01am *last updated 25/08/2016;11:01 am by MISS JENNIFER CROSBIE*

Allergy/Intolerance	Reaction
No Known Drug Allergies	

Allergy records are as recorded at time and date of printing

Drug	Dose	Route	Frequency	Days Supply	GP to continue
AMITRIPTYLINE 10 mg Tablets	**10 mg**	Oral	ONCE daily at 10pm	28	Yes

New medication - last updated on 25/08/16 byMISS JENNIFER CROSBIE

Additional Medicines Information:

Acute Medicine Department
~~NHS Ayrshire & Arran, Crosshouse~~
Hospital, Kilmarnock, KA2 0BE
This IDL to be considered as final discharge letter
Signature/Stamp:
Dr Maharth Manuel
Consultant Physician
Acute Medicine
GMC 6041033 Page 3763
Date: 25/8/16

Discharged by : DR FATIMA CHAUDHRY
Grade: Foundation Year 1
Dispensed by:
Date:
Checked by:

University Hospital Crosshouse,
Kilmarnock Road, Kilmarnock,
KA2 0BE
Phone: 01563 521133

Immediate Discharge Letter & Prescription

Processed by Pharmacy

NHS Ayrshire & Arran

To: Sharma, Dr. A,
9 FREW TERRACE,
IRVINE,
KA12 9DY

Re: STEPHEN GALLOWAY
28 REDBURN PLACE,IRVINE,AYRSHIRE,KA12 9BH

DOB: 14/06/1965
Hosp. No.: 1406650854
CHI No.: 1406650854

Medicines discontinued during admission (medicines that patient was recorded as admitted on only)

Drug	Date	Discontinued by	Discontinue reason
DIAZEPAM - CIWAAR REGIMEN - AS CHARTED	25/08/2016	DR FATIMA CHAUDHRY	Course Complete

*** ***Warning*** - *accuracy of information in this section is dependent on details entered by users of the HEPMA system.*** ****Information here may be incomplete and is for guidance only.****

Discharged by : DR FATIMA CHAUDHRY **Dispensed by:** **Checked by:**

Grade: Foundation Year 1 **Date:**

Confidential - Clinical Information

Department of Cardiology and General Medicine
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
Tel: 01563 521133
01563 827973
www.nhsaaa.net

NHS Ayrshire & Arran

Dr A Sharma
Frew Terrace Surgery
9 Frew Terrace
Irvine
Ayrshire
KA12 9DY

Our Ref:	VC/PJ
Hospital No:	
Clinic Date:	21/11/2015
Date Dictated:	21/11/2015
Date Typed:	28/11/2015
Enquiries to	Eleanor Wright
Direct Line:	01563 827905
Ext. Number:	27905
Email:	eleanor.wright@aaaht.scot.nhs.uk

Dear Dr Sharma,

STEPHEN GALLOWAY DOB: 14/06/1965 CHI No: 1406650854
28 REDBURN PLACE, IRVINE, AYRSHIRE, KA12 9BH

Mr Galloway has defaulted twice from his new Cardiology Clinic appointment. No further appointment will be sent.

Kind regards.

Yours sincerely

This document has NOT been verified

Dr Victor Chong
Consultant Cardiologist / Physician
GMC: 4607229

MEDICAL

INVESTING IN VOLUNTEERS

STA0606

Confidential - Clinical Information

Department of Cardiology and General Medicine
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
01563 521133
01563 827973
www.nhsaaa.net

NHS Ayrshire & Arran

Dr A Sharma
Frew Terrace Surgery
9 Frew Terrace
Irvine
Ayrshire
KA12 9DY

Our Ref:	VC/EW
Hospital No:	
Clinic Date:	03/08/2015
Date Dictated:	03/08/2015
Date Typed:	06/08/2015
Enquiries to	Eleanor Wright/Caroline Daniels
Direct Line:	01563 827905
Ext. Number:	27905
Email:	Eleanor.Wright@aaaht.scot.nhs.uk

Dear Dr Sharma,

STEPHEN GALLOWAY DOB: 14/06/1965 CHI No: 1406650854
28 REDBURN PLACE, IRVINE, AYRSHIRE, KA12 9BH

I regret to inform you that Mr Galloway failed to attend his new cardiology clinic appointment today. No further appointment will be sent pending your advice.

With kind regards

Yours sincerely

This document has NOT been verified

Dr Victor Chong
Consultant Cardiologist / Physician
GMC: 4607229

MEDICAL

INVESTING IN VOLUNTEERS

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 1010097942661

REFERRAL LETTER

CHI:1406650854

MEDICAL IN CONFIDENCE

REFERRAL TO

CardiologyA2
AA Gen Ref - PMH Med & High

University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
Ayrshire
KA2 0BE

Ethnic Origin	(White) Scottish
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine	see attachment
Date of referral	18-Aug-2015	
Date submitted	19-Aug-2015	

PATIENT DETAILS

Surname	Galloway
Forename(s)	Stephen
Title	-
Sex	Male
Date of birth	14-Jun-1965
CHI no.	1406650854

Patient's address

28 Redburn Place
Irvine
KA12 9BH

Contact number(s)

Voice: 07468 337186

REGISTERED GP DETAILS

Name	Dr Duncan McNab		
GMC code	4507903	GP code	20265
Practice name	Frew Terrace Surgery (16883)		
Practice code	80698		

Practice address

9 Frew Terrace
Irvine

Contact number(s)

Voice: 01294 272326
Facsimile: 01294 312614

REFERRING PRACTITIONER DETAILS

Name	Dr. Avichal Sharma		
GMC code	6077543	GP code	20141
Practice name	Frew Terrace Surgery (80698)		
Practice code	80698		

Practice address

9 Frew Terrace
Irvine
Ayrshire
KA12 9DY

Contact number(s)

Voice: 01294 272326

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: see letter ks

Comment: Dear Colleague, I would appreciate if you could reallocate this patient an appointment. He has updated us that he mixed up the dates of his appointment. Please find enclosed a copy of my original referral and your recent correspondence. Yours sincerely

Examinations and Investigations

Height:	168 -	
Weight(kg):	70 -	
BMI:	24.8 -	
Moderate smoker - 10-19 cigs/d:		28-Jan-2015
Smoker :		28-Jan-2015
Current smoker:		28-Jan-2015
Moderate smoker - 10-19 cigs/d:		09-Jan-2014
Current smoker:		09-Jan-2014

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Erectile dysfunction	-	-	-	04-Apr-2014	04-Apr-2014
Anxiety with depression	-	-	-	22-Feb-2012	22-Feb-2012
Suicidal ideation	-	-	-	15-Dec-2011	15-Dec-2011
Erectile dysfunction	-	-	-	24-Jul-2008	24-Jul-2008
Balanitis	-	-	Recurrent	20-Jan-2005	20-Jan-2005
Chronic diarrhoea	-	-	-	16-Jan-2005	16-Jan-2005
Ganglion of joint	-	-	Right lateral mallelolus	08-Sep-2004	08-Sep-2004
O/E - Wound infected	-	-	Right ring finger. Laceration explored in theatre 5 days previously	16-May-2002	16-May-2002
In prison	-	-	Liberated 19/4/02	17-Apr-2002	17-Apr-2002
Suicide and selfinflicted injury caustic subst, excl poison	-	-	Deliberate ingestion of 50 mls disinfectant (methylated spirits)	21-Jul-2001	21-Jul-2001

Haematemesis	-	-	Admitted. Diazepam for withdrawal	11-Oct-1999	11-Oct-1999
Gastro-oesophageal reflux with oesophagitis	-	-	Gastric ulcer. Gastritis	11-Oct-1999	11-Oct-1999
[X]Self inflicted injury	-	-	Stab wound. Refused psychiatric referral	05-Apr-1997	05-Apr-1997
Suicide + selfinflicted poisoning by drug or medicine NOS	-	-	Paracetamol. Alcohol intoxication. Charged with drinking and driving. Abusive and aggressive. Irregular discharge	07-Jan-1996	07-Jan-1996
Closed fracture of mandible, angle of jaw	-	-	-	14-Nov-1987	14-Nov-1987

Past procedures

Description	Laterality	Modifier	Comments	Date performed	Recorded Date
Ultrasound of scrotum	-	-	Small hydrocele	18-Apr-2012	18-Apr-2012
Ultrasound of testes	-	-	Normal	21-Mar-2012	21-Mar-2012
Reduction of fracture of zygomatic bones (Left)	Left	-	-	07-Jul-2006	07-Jul-2006
Bilateral vasectomy for contraception	-	-	-	22-Apr-2005	22-Apr-2005
Standard circumcision	-	-	-	22-Apr-2005	22-Apr-2005
Endoscopy normal	-	-	-	10-Mar-2005	10-Mar-2005
Colonoscopy normal	-	-	-	10-Mar-2005	10-Mar-2005
CLO test for helicobacter pylori	-	-	Positive	25-Nov-1999	25-Nov-1999
Alcohol detoxification	-	-	Failed to keep 2 appointments so discharged.	25-Jul-1997	25-Jul-1997

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Lansoprazole Capsules (Gastro-Resistant) 30 mg	0103050L0AAAAAA	56 capsule	ONE TO BE TAKEN EACH DAY	-	21-Feb-2014	-	08-May-2015
Tadalafil Tablets 5 mg	-	8 TABLET	TO BE TAKEN AS DIRECTED	-	14-Jan-2014	-	14-Aug-2015

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date

Amoxicillin Capsules 500 mg	-	28 capsule	2 Tabs bd	-	22-Jul-2015	42 Days	22-Jul-2015
Clarithromycin Tablets 500 mg	0501050B0AAADAD	14 tablet	ONE TO BE TAKEN TWICE A DAY	-	22-Jul-2015	7 Days	22-Jul-2015

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status

Number per day
? (not known)

Alcohol consumption

Units per day
? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

Social circumstances

Signature of referring doctor (or other professional) **Date**

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 1010086247421

REFERRAL LETTER

MEDICAL IN CONFIDENCE

CHI:1406650854

REFERRAL TO

CardiologyA2
AA Gen Ref - PMH Med & High

University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
Ayrshire
KA2 0BE

Ethnic Origin	(White) Scottish
Language Interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing Impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	29-Jan-2015
Date submitted	30-Jan-2015

PATIENT DETAILS

Surname	Galloway
Forename(s)	Stephen
Title	-
Sex	Male
Date of birth	14-Jun-1965
CHI no.	1406650854

Patient's address

28 Redburn Place
Irvine
KA12 9BH

Contact number(s)

Voice: 07747 692 927

REGISTERED GP DETAILS

Name	Dr Duncan McNab		
GMC code	4507903	GP code	20265
Practice name	Frew Terrace Surgery (16883)		
Practice code	80698		

Practice address

9 Frew Terrace
Irvine

Contact number(s)

Voice: 01294 272326
Facsimile: 01294 312614

REFERRING PRACTITIONER DETAILS

Name	Dr. Avichal Sharma		
GMC code	6077543	GP code	20141
Practice name	Frew Terrace Surgery (80698)		
Practice code	80698		

Practice address

9 Frew Terrace
Irvine
Ayrshire
KA12 9DY

Contact number(s)

Voice: 01294 272326

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: AC

Comment: Dear ColleagueMany thanks for reviewing this 49 year old male to exclude angina. He presents with a 2-3 week history of an intermittent "weight" sensation to the central chest. This can last up to twenty minutes at a time and occurs on exertion and at rest. He feels it is different from his known reflux and he denies any similar episodes in the past. He admits he is under a lot of pressure at the moment seeking employment. He is a smoker and is currently abstinent from alcohol. He admits previous alcohol excess about ten years ago. He was referred to CDU and I enclose a copy of there discharge letter. The patient states he was told he may have angina. He is certainly keen to rule this out having always previously been fit. He further mentioned an intermittent cough with dirty sputum over this same period and we are covering him with the possibility of a chest infection at present. Clinically this patient is well and has a flat affect. Otherwise cardiovascular, respiratory, gastrointestinal, cath examination was unremarkable. We are covering the possibility of mood and also a lower respiratory tract infection being contributing factors to the patients current chest pain symptoms. I would however value your opinion as to whether or not this gentleman has angina. You may be able to seek further information from the CDU, however, no follow up has been mentioned. We have commenced a GTN spray if required in the meantime.Yours sincerely

Examinations and Investigations

Height:	168	-
Weight(kg):	70	-
BMI:	24.8	-
Moderate smoker - 10-19 cigs/d:	28-Jan-2015 00:00	
Smoker :	28-Jan-2015 00:00	
Current smoker:	28-Jan-2015 00:00	
Moderate smoker - 10-19 cigs/d:	09-Jan-2014 00:00	
Current smoker:	09-Jan-2014 00:00	

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Chest pain	-	-	-	21-Jan-2015	21-Jan-2015
Erectile dysfunction	-	-	-	04-Apr-2014	04-Apr-2014
Anxiety with depression	-	-	-	22-Feb-2012	22-Feb-2012
Suicidal ideation	-	-	-	15-Dec-2011	15-Dec-2011
Erectile dysfunction	-	-	-	24-Jul-2008	24-Jul-2008
Balanitis	-	-	Recurrent	20-Jan-2005	20-Jan-2005
Chronic diarrhoea	-	-	-	16-Jan-2005	16-Jan-2005
Ganglion of joint	-	-	Right lateral mallelolus	08-Sep-2004	08-Sep-2004
O/E - Wound infected	-	-	Right ring finger. Laceration explored in theatre 5 days previously	16-May-2002	16-May-2002
In prison	-	-	Liberated 19/4/02	17-Apr-2002	17-Apr-2002
Suicide and selfinflicted injury caustic subst, excl poison	-	-	Deliberate ingestion of 50 mls disinfectant (methylated spirits)	21-Jul-2001	21-Jul-2001

Haematemesis	-	-	Admitted. Diazepam for withdrawal	11-Oct-1999	11-Oct-1999
Gastro-oesophageal reflux with oesophagitis	-	-	Gastric ulcer. Gastritis	11-Oct-1999	11-Oct-1999
[X]Self inflicted injury	-	-	Stab wound. Refused psychiatric referral	05-Apr-1997	05-Apr-1997
Suicide + selfinflicted poisoning by drug or medicine NOS	-	-	Paracetamol. Alcohol intoxication. Charged with drinking and driving. Abusive and aggressive. Irregular discharge	07-Jan-1996	07-Jan-1996
Closed fracture of mandible, angle of jaw	-	-	-	14-Nov-1987	14-Nov-1987

Past procedures

Description	Laterality	Modifier	Comments	Date performed	Recorded Date
Ultrasound of scrotum	-	-	Small hydrocele	18-Apr-2012	18-Apr-2012
Ultrasound of testes	-	-	Normal	21-Mar-2012	21-Mar-2012
Reduction of fracture of zygomatic bones (Left)	Left	-	-	07-Jul-2006	07-Jul-2006
Bilateral vasectomy for contraception	-	-	-	22-Apr-2005	22-Apr-2005
Standard circumcision	-	-	-	22-Apr-2005	22-Apr-2005
Endoscopy normal	-	-	-	10-Mar-2005	10-Mar-2005
Colonoscopy normal	-	-	-	10-Mar-2005	10-Mar-2005
CLO test for helicobacter pylori	-	-	Positive	25-Nov-1999	25-Nov-1999
Alcohol detoxification	-	-	Failed to keep 2 appointments so discharged.	25-Jul-1997	25-Jul-1997

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Lansoprazole Capsules (Gastro-Resistant) 30 mg	0103050L0AAAAAA	56 capsule	ONE TO BE TAKEN EACH DAY	-	21-Feb-2014	-	22-Jul-2014
Tadalafil Tablets 5 mg	-	8 TABLET	TO BE TAKEN AS DIRECTED	-	14-Jan-2014	-	22-Jan-2015

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Amoxicillin Capsules 500 mg	-	21 capsule	1 TID	-	28-Jan-2015	42 Days	28-Jan-2015
Glyceryl Trinitrate Cfc-free pump spray 400 micrograms/dose (180 dose)	-	1 spray	2 Puffs Take as required	-	28-Jan-2015	42 Days	28-Jan-2015

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status

Number per day
? (not known)

Alcohol consumption

Units per day
? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

Social circumstances

Signature of referring doctor (or other professional) **Date**

STA0849

NHS AYRSHIRE & ARRAN

Crosshouse Hospital Discharge

392153

G.P.

* PLEASE PRINT HEAVILY USING BALL POINT PEN

CHI: 1406650854
Galloway, Stephen
66 Garnock Street
Dalry
KA24 4AW
14/06/1965
Dr ML Perman
MRN: XH1468158
Date of Birth:

Ward: CCU
Consultant: Chung.
Date of Admission: 21-01-15
Date of Discharge: 22-01-15
(or date of death)
Clinic Appointment: no f/up

Services Arranged: ☐ Home help ___ times week ☐ Meals on wheels ☐ District Nurse ☐ Other
Discharged to: ☐ Home ☐ Stay with relatives ☐ Other hospital ☐ Nursing home ☐ Other ☐ Died

Discharge Diagnosis (if admitted due to an injury, include place of accident & site of injury)	If multiple Day Case admission, list dates of admission
1 Chest Pain - TROPonin <0.03	
2	
3	
4	
5	

Operations / Procedures
1 CXR - nil focal
2 ECG NSR
3 TROPT <0.03
4 EXT - nil acute

Discharge Medication (7 days supply will be dispensed unless otherwise stated by doctor)

For Pharmacy use

Drug Name and formulation	Dose	Frequency	Route	Duration (cont/stop)	Quantity and strength	Notes
no new Medications						
				pharmacy date	dispensed by	checked by

Additional Information (e.g. awaiting histology or other results, patients progress)

A finished consultant episode letter will follow.

Signature _____

PRINT NAME Kam Egs Date 22/01/2015

N.B. DISCHARGE MEDICATION IS FOR INFORMATION ONLY. FAXED COPY HAS NOT BEEN CHECKED BY DOCTOR. ON RECEIPT OF HARD COPY, FAXED COPY CAN BE DESTROYED.

Ward Clerkess: _____ / Dictated: _____ / Typed: _____ / Signed: _____ / Mailed: _____

Confidential - Clinical Information

Clinical Decisions Unit
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
01563 825056
01563 827731
www.nhsaaa.net

NHS Ayrshire & Arran

Dr A Sharma
Frew Terrace Surgery
9 Frew Terrace
Irvine
Ayrshire
KA12 9DY

Our Ref: KF/GD
Hospital No: 1406650854
Date Dictated: 22/01/2015
Date Typed: 12/02/2015
Enquiries to Lorraine Ritchie
Direct Line 01563 825056
Ext. Number 25056
Email lorraine.ritchie@aaaht.scot.nhs.uk

Dear Dr Sharma,

STEPHEN GALLOWAY DOB: 14/06/1965 CHI No: 1406650854
28 REDBURN PLACE, IRVINE, AYRSHIRE, KA12 9BH

ADMITTED: 21/01/2015

DISCHARGED: 22/01/2015

DIAGNOSIS: Chest pain – Troponin negative.

MEDICATION ON DISCHARGE: No new medication.

FOLLOW-UP: No further follow up required.

The above 49 year old gentleman was admitted to the Clinical Decisions Unit, Crosshouse Hospital with a history of chest discomfort for several days. He described it as a crushing heaviness in the centre of his chest. It had no associated features and it did not radiate.

He gave no family history of ischaemic heart disease, is a smoker of 15 cigarettes per day, no history of hypertension, hyperlipidemia or diabetes. ASSIGN score was calculated at 14%.

Cardiovascular and respiratory examinations were unremarkable. ECG showed sinus rhythm with no acute changes. Chest x-ray was normal. 12 hour Troponin was negative at less than 0.03.

He was reviewed by Dr Chung, Consultant in Emergency Medicine and an in-patient exercixe tolerance test was performed. Mr Galloway exercised for 12 minutes, there was no acute changes and no chest pain. This was reviewed by Mr Chung, ED Consultant and was therefore discharged home with no further follow up required.

Yours sincerely

This document has NOT been verified

INVESTING IN YOU

Karen Figgins
Advanced Nurse Practitioner
NMC No. 84B05545

Mr D Chung
Consultant in Emergency Medicine
GMC 4304124

STA0849

NHS AYRSHIRE & ARRAN

Crosshouse Hospital Discharge

392153

G.P.

CHI: 1406650854
Galloway, Stephen
66 Garnock Street
Dairy
KA24 4AW
14/06/1965
Dr ML Perman
MRN: XHI468158
Date of Birth

* PLEASE PRINT HEAVILY USING BALL POINT PEN

Ward: CCU
Consultant: CHUNG.
Date of Admission: 21.01.15
Date of Discharge: 22.01.15
(or date of death)
Clinic Appointment: NO F/UP

Services Arranged: ☐ Home help ___ times week ☐ Meals on wheels ☐ District Nurse ☐ Other
Discharged to: ☐ Home ☐ Stay with relatives ☐ Other hospital ☐ Nursing home ☐ Other ☐ Died

Discharge Diagnosis (if admitted due to an injury, include place of accident & site of injury)
1 Chest Pain - TROPonin <0.03
2
3
4
5

If multiple Day Case admission, list dates of admission

Operations / Procedures
1 Cxr - nil focal
2 ECG NSR
3 TROPT <0.03
4 ETT - Nil acute

Discharge Medication (7 days supply will be dispensed unless otherwise stated by doctor)

For Pharmacy use

Drug Name and formulation	Dose	Frequency	Route	Duration (cont/stop)	Quantity and strength	Notes
no new medications						

pharmacy date | dispensed by | checked by

Additional Information (e.g. awaiting histology or other results, patients progress)

A finished consultant episode letter will follow.

Signature _____

PRINT NAME Kam Kgs Date 22/01/2015

N.B. DISCHARGE MEDICATION IS FOR INFORMATION ONLY. FAXED COPY HAS NOT BEEN CHECKED BY DOCTOR. ON RECEIPT OF HARD COPY, FAXED COPY CAN BE DESTROYED.

Ward Clerkess : _____ / Dictated : _____ / Typed : _____ / Signed : _____ / Mailed : _____

3t

A80698 Frew Terrace Surgery 21 01 2015
Phone 01294 272326

Referral to Hospital

Specialty **Medical Receiving**
Referring GP **Dr L McElwee**

Patient
Stephen Galloway (Phone no: 07747 692 927)

28 Redburn Place
Irvine
KA12 9BH

Age 49 years
CHI 1406650854

Problem

Dear Colleague,

Thank you for accepting this patient. Please see my consultation notes below.

Yours sincerely

Consultations - Last 10

	21/01/2015, Main Surgery, Dr Louise McElwee
(First) Problem	Chest pain
History	History of intermittent chest pain for two weeks. Feels heaviness over sternum. First time came on when walking to shops. Aside from this episode seems to come on unprovoked, can occur at rest. Also having sharp exacerbations of stabbing type pain which quickly self resolve. Not particularly brought on by cold/exercise.

	Did have cough a few weeks ago but this has now completely resolved. Pain is not pleuritic in nature. Sometimes short of breath and wheezy. States had childhood asthma. Not sweating/nauseated. Also describing stonger smelling urine which is more concentrated for last few weeks. Having bilateral loin pain. Intermittent ache. Generally has been feeling tired and unwell. Mr Galloway is unsure of family history of cardiac disease. No calf pain/swelling.
Examination	Temp 35.2, HR 82, SPO2 98%, BP 130/80. Pulse regular. Heart sounds pure. Chest clear. Not tender to palpation over sternum. Abdomen soft, non-tender, bowel sounds active.
Social	Smokes 15x cigarettes per day since age 11. Rolls own cigarettes.Not currently working.
Result	Discussed with Dr McHugh. Possible GI in origin but unable to exclude cardiac cause for pain. Likely needs ECG and troponin. Advises refer medics. Have discussed with on-call physician. Kindly accepts patient. 2 hour ambulance.
	21/01/2015, Main Surgery, Miss Christie McCormick
Comment	2 hour ambulance arrnged, coming to surgery to pick up patient - ref 1870536
	31/07/2014, Docman, Dr Doc Docman
Additional	Letter from consultant A&E Letter Western Infirmary Accident & Emergency Dr Scott Hepburn
	23/07/2014, Special Request, Dr Catriona McHugh
History	on lansoprazole 30- had +ve h pylori but doesn't look like attended for treatment. also FTA UGIE. issued but instructed to attend for r/v
	06/05/2014, Docman, Dr Doc Docman
Additional	Letter from consultant Hospital Letter Ayrshire Central Nutrition + Diet Therapy
	17/04/2014, Docman, Dr Doc Docman
Additional	Letter from consultant Hospital Letter Crosshouse Hospital Endoscopy Department
	11/04/2014, Main Surgery, Dr Vikas Shetty
(Review) Problem	Erectile dysfunction
History	see notes from 4/4/14- requested 84 tadalafil since jan 2014-pt says takes 1 tablet every day whether he is having sex or not, as was told to do so by his previous GPm in dalry
Comment	explained taking tablet daily is against guidelines-plan-8 tabs prescribed-adv to see own GP.

	09/04/2014, Docman, Dr Doc Docman
Additional	Result Result Crosshouse Hospital haematolgy
	09/04/2014, Main Surgery, Miss Christina Blair
Comment	Previously raised ESR. Wishes re-checked. ESR taken
	04/04/2014, Special Request, Dr David Cunningham
(New) Problem	Erectile dysfunction
History	has requested 84 tablets of tadalafil since end of January 2014 as far as I can see. needs to speak to usual doctor about this prescription, I think this exceeds NHS 'ration' which was 8 tablets per month. note to patient.

Problem - All

	Details
Active	
04/04/2014	Erectile dysfunction

Current Repeat Prescriptions

Medication - All

	Details	Dosage/Quantity
Current Repeat		
22/07/2014P	Lansoprazole Capsules (Gastro-Resistant) 30 mg	ONE TO BE TAKEN EACH DAY, 56 capsule
09/01/2015P	Tadalafil Tablets 5 mg	TO BE TAKEN AS DIRECTED, 8 TABLET

Recent Acute Prescriptions (last 3 months)

Medication - From 3M Ago To Present

	Details	Dosage/Quantity

Medication - From 3M Ago To Present

	Details	Dosage/Quantity

Hospital use only	Clinic	Day Date	Time	Hospital No.
	CLINIC AFTER Endo Plist AAS			

Transport required?

Unique Care Pathway Number: 101006781280M

REFERRAL LETTER

CHI:1406650854

MEDICAL IN CONFIDENCE

REFERRAL TO

GastroenterologyA9
AA Gen Ref - PMH Med & High

University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
Ayrshire
KA2·0BE

Ethnic Origin	(White) Scottish
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	24-Feb-2014
Date submitted	25-Feb-2014

PATIENT DETAILS

Surname	Galloway
Forename(s)	Stephen
Title	-
Sex	Male
Date of birth	14-Jun-1965
CHI no.	1406650854

Patient's address

26 Martin Avenue
Irvine
KA12 9NY

Contact number(s)

Voice: 07511270239

REGISTERED GP DETAILS

Name	Dr Duncan McNab		
GMC code	4507903	GP code	20265
Practice name	Frew Terrace Surgery (16883)		
Practice code	80698		

Practice address

9 Frew Terrace
Irvine

Contact number(s)

Voice: 01294 272326
Facsimile: 01294 312614

REFERRING PRACTITIONER DETAILS

Name	Dr. Agomeze Chigo Igwe-Omoke		
GMC code	6095095	GP code	99999
Practice name	Frew Terrace Surgery (80698)		
Practice code	80698		

Practice address

9 Frew Terrace
Irvine
AYRSHIRE
KA12 9DY

Contact number(s)

Voice: 01294 272326

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: see letter ks

Comment: Dear Colleague,Many thanks for seeing this 48 year old gentleman who has been having recurrent epigastric pain for a few months now. He recently told me that over the past one week he has been having black pellet, rabbit like droppings but denies any overt weight loss or PR bleeding or haematemesis / haemoptysis. I would be grateful for your kind review and assessment for him to rule out any sinister pathology following OGD. Yours sincerely

Examinations and Investigations

Height:	168	-
Weight(kg):	70	-
BMI:	24.8	-

Moderate smoker - 10-19 cigs/d: 09-Jan-2014 00:00

Current smoker: 09-Jan-2014 00:00

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Lansoprazole Capsules (Gastro-Resistant) 30 mg	0103050L0AAAAAA	56 capsule	ONE TO BE TAKEN EACH DAY	-	21-Feb-2014	-	21-Feb-2014
Tadalafil Tablets 5 mg	-	28 TABLET	TO BE TAKEN AS DIRECTED	-	14-Jan-2014	-	10-Feb-2014

Recent medication (Any medication issued within last 90 days not shown above)

No recent medications recorded

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status: Number per day ? (not known)

Alcohol consumption: Units per day ? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

Social circumstances

Signature of referring doctor (or other professional) **Date**

Confidential - Clinical Information

Department of Urology
University Hospital Ayr
Dalmellington Road
Ayr
KA6 6DX
01292 610555

www.nhsayrshireandarran.com

NHS Ayrshire & Arran

Dr JA Taylor
Dalry Medical Practice
Dalry Health Centre
50 Vennel Street
Dalry
KA24 4AF

Our Ref: DR/LP
Hospital No:
Clinic Date: 02/11/2012
Date Dictated: 02/11/2012
Date Typed: 06/12/2012
Enquiries to Maureen McCreadie
Direct Line:
Ext. Number: 14305
Email: maureen.mccreadie@aaaht.scot.nhs.uk

Dear Dr Taylor,

STEPHEN GALLOWAY DOB: 14/06/1965 CHI No: 140 665 0854
66 GARNOCK STREET, DALRY, AYRSHIRE, KA24 4AW

Mr Galloway has not contacted me since he failed to attend my Clinic in July.

I assume that he is continuing to respond well to Tadalafil.

I plan no further follow up for him although he has my contact number should he need advice.

Yours sincerely

Authorised on 12/12/2012 11:23:31 by Derek Rutherford.

Derek Rutherford
Consultant Nurse in Men's Health/Sexual Medicine PhD

INVESTING IN VOLUNTEERS

Confidential - Clinical Information

Department of Urology
University Hospital Ayr
Dalmellington Road
Ayr
KA6 6DX
Phone No 01292 610555
Fax 01292 614641
www.nhsayrshireandarran.com

NHS Ayrshire & Arran

Dr J A Taylor
Dalry Medical Practice
Dalry Health Centre
50 Vennel Street
Dalry
KA24 4AF

Our Ref:	DR/LT
Hospital No:	
Clinic Date:	19/06/2012
Date Dictated:	20/06/2012
Date Typed:	21/06/2012
Enquiries to	Ann Anderson
Direct Line:	01292 610555
Ext. Number:	14305
Email:	anne.anderson@aaaht.scot.nhs.uk

Dear Dr Taylor,

STEPHEN GALLOWAY DOB: 14/06/1965 CHI No: 1406650854
66 GARNOCK STREET, DALRY, AYRSHIRE, KA24 4AW

Stephen re-attended my clinic for review on the 19th June 2012. He is continuing to respond to 20mgs of Tadalafil (Cialis) and he has experienced no side effects. He is now using the treatment to its best effect and is happy with his response. He asked about obtaining Tadalafil 20mgs from your practice rather than obtaining treatment from Ayr Hospital. He has certainly experienced upset and distress due to the consequences of erectile dysfunction. His quality of life has now improved. When I saw him on 17th April 2012 he was reluctant to establish a relationship due to lack of confidence and low self esteem. His confidence has greatly improved and his mood is also much better.

He qualifies for treatment on the NHS due to the distress he experienced as a consequence of ED. It was decided at a recent General Practitioner subcommittee meeting to implement the Scottish Government's amendment to Schedule 2 prescribing of ED treatment within Ayrshire and Arran.

In the meantime I have arranged another prescription for Stephen and I will see him in four months for review. He has my contact number should he need advice.

Yours sincerely

Authorised on 21/06/2012 17:20:00 by Derek Rutherford.

Derek Rutherford
Consultant Nurse

INVESTING IN VOLUNTEERS

Confidential - Clinical Information

Department of Urology
University Hospital Ayr
Dalmellington Road
Ayr
KA6 6DX
01292 610555

www.nhsayrshireandarran.com

NHS Ayrshire & Arran

Dr JA Taylor
Dalry Medical Practice
Dalry Health Centre
50 Vennel Street
Dalry
KA24 4AF

Our Ref:	DR/CIK
Hospital No:	100-750249
Clinic Date:	23/05/2012
Date Dictated:	23/05/2012
Date Typed:	04/06/2012
Enquiries to	Ann Anderson
Direct Line:	
Ext. Number:	14305
Email:	ann.anderson@aaaht.scot.nhs.uk

Dear Dr Taylor,

STEPHEN GALLOWAY DOB: 14/06/1965 CHI No: 1406650854
66 GARNOCK STREET, DALRY, AYRSHIRE, KA24 4AW

Mr Galloway re-attended my Clinic today

He failed to respond to 20mg of Tadalafil (Cialis) however, on discussion with him, he has not been using the treatment to its best effect. Despite counselling him on the long duration of action associated with Tadalafil, he had been expecting a response within half and hour.

I have again advised him again on how to use tadalafil and he will adhere to my advice. I will see him in 4 weeks for review.

Yours sincerely

Authorised on 06/06/2012 12:07:24 by Derek Rutherford.

Derek Rutherford
Consultant Nurse

INVESTING IN VOLUNTEERS

Confidential - Clinical Information

Department of Urology
Erectile Dysfunction Clinic
University Hospital Ayr
Dalmellington Road
Ayr
KA6 6DX
01292 610555
01292 288952
www.nhsayrshireandarran.com

NHS Ayrshire & Arran

Dr Taylor
Dalry Medical Practice
Dalry Health Centre
50 Vennel Street
Dalry
KA24 4AF

Our Ref:	DR/AA
Hospital No:	100750249
Clinic Date:	18/04/2012
Date Dictated:	18/04/2012
Date Typed:	10/05/2012
Enquiries to	Ann Anderson
Direct Line:	
Ext. Number:	ext 14305
Email:	anne.anderson@aaaht.scot.nhs.uk

Dear Dr Taylor,

STEPHEN GALLOWAY DOB: 14/06/1965 CHI No: 1406650854
66 GARNOCK STREET, DALRY, AYRSHIRE, KA24 4AW.

Mr Galloway re-attended my clinic today. He was seen at the Urology clinic and Mr Mohammed arranged for him to have scrotal ultrasound, which revealed a small hydrocele but no significant abnormality in terms of the pain he experiences. He told me that the pain is more significant in the left side in the inguinal groin region and when he puts pressure on this area in response to the pain, his pain is often relieved. Since I last saw him he told me he had been commenced on Trazadone, although he has stopped taking the medication soon after it was commenced. I am unsure if he informed that he is no longer taking Trazadone. He last attended my clinic in March 2010 and at that time you had arranged for him to have a trial with 20mgs of Tadalafil (Cialis). He did not buy 20mgs of Tadalafil. He told me that his tablets were confiscated by the police following a domestic incident.

Although he has a good urinary flow, he told me that he experiences pain on micturition and he had thorough examination at the Urology clinic by Mr Mohammed and no abnormality was noted. I will however, copy this letter to Mr Gurun as Mr Gurun may wish to carry out further investigation including cystoscopy. He told me that the pain he experiences severe and often unbearable. From his account of events it certainly merits further investigation. He has had vasectomy and circumcision in the past. He told me that there is no possibility that he has a sexually transmitted infection and he told me he has submitted a urine specimen for routine urine analysis recently. Currently he obtains only a partial erection, which is difficult to sustain. I think it would be reasonable for him to continue with Tadalafil (Cialis) and he will have another trial with 10mgs. I have arranged this for him from my clinic today.

Cont/.....

INVESTING IN VOLUNTEERS

STEPHEN GALLOWAY

I reiterated the potential side affects including retinal vein occlusion, retinal haemorrhage and loss of vision and I also advised him that hearing loss has been linked to PDE5 Inhibitors. He does not have a history of eye disease. He is smoking 15 cigarettes per day and he takes no alcohol. He told me that he had stopped smoking cannabis. He is not in a relationship and is inhibited about establishing a relationship because of his sexual dysfunction. He keeps himself fit by cycling. I will see him again in five weeks for review and I will keep you updated on his progress.

Yours sincerely

Authorised on 15/05/2012 15:03:24 by Derek Rutherford.

Derek Rutherford
Consultant Nurse

Cc Mr Gurun, Consultant Urologist

INVESTING IN VOLUNTEERS

Confidential - Clinical Information

Department of Urology
Ayr Hospital
Dalmellington Road
Ayr
KA6 6DX
01292 610555
01292 614609
www.nhsayrshireandarran.com

NHS Ayrshire & Arran

Stephen Galloway
66 Garnock Street
Dalry
Ayrshire
KA24 4AW

Our Ref:	BL/KJ/ **1406650854**
Ref Date:	21/03/2012
Date Dictated:	21/03/2012
Date Typed:	22/03/2012
Enquiries to	Miss Karen Johnston
Direct Line:	
Ext. Number:	14691
Email:	karen.johnston@aaaht.scot.nhs.uk

Dear Mr Galloway,

This is just to let you know that your testicular ultrasound scan was normal which is excellent news.

Yours sincerely

Authorised on 22/03/2012 16:28:49 by Brian Little.

Mr B Little
Consultant Urological Surgeon
GMC: 4187488

Dr ML Perman
Dalry Medical Practice
Dalry Health Centre
50 Vennel Street
Dalry
KA24 4AF

INVESTING IN VOLUNTEERS

Confidential - Clinical Information

Department of Urology
Ayr Hospital
Dalmellington Road
Ayr
KA6 6DX
01292 610555
01292 614609
www.nhsayrshireandarran.com

NHS Ayrshire & Arran

Stephen Galloway
66 Garnock Street
Dalry
Ayrshire
KA24 4AW

Our Ref:	BL/KJ/ **1406650854**
Ref Date:	14/03/2012
Date Dictated:	14/03/2012
Date Typed:	16/03/2012
Enquiries to	Miss Karen Johnston
Direct Line:	
Ext. Number:	14691
Email:	karen.johnston@aaaht.scot.nhs.uk

Dear Mr Galloway,

This is just to let you know your recent blood tests were normal, particularly testosterone levels and your Prolactin levels.

Yours sincerely

Authorised on 22/03/2012 13:40:21 by Brian Little.

Mr B Little
Consultant Urological Surgeon
GMC: 4187488

Dr ML Perman
Dalry Medical Practice
Dalry Health Centre
50 Vennel Street
Dalry
KA24 4AF

INVESTING IN VOLUNTEERS

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

Unique Care Pathway Number: 1010029350870

REFERRAL LETTER

CHI:1406650854

MEDICAL IN CONFIDENCE

REFERRAL TO

UrologyCB
AA Gen Ref - PMH Med & High

Ayr Hospital
Dalmellington Road
Ayr
KA6 6DX

Ethnic Origin	(White) Scottish
Language interpreter req'd	-
Religion	-
Religious Observance	-
Vision impairment	-
Hearing impairment	-
Sign language interpreter req'd.	-

Urgency of referral	Routine
Date of referral	14-Dec-2011
Date submitted	20-Dec-2011

PATIENT DETAILS

Surname	Galloway
Forename(s)	Stephen
Title	-
Sex	Male
Date of birth	14-Jun-1965
CHI no.	1406650854

Patient's address

66 Garnock St
Dalry
KA24 4AW

Contact number(s)

Voice: 07511 670274

REGISTERED GP DETAILS

Name	Dr Michael Perman		
GMC code	6056072	GP code	20087
Practice name	Dalry Health Centre		
Practice code	80217		

Practice address

50 Vennel Street
Dalry

Contact number(s)

Voice: 01294-832523
Facsimile: 01294-835771

REFERRING PRACTITIONER DETAILS

Name	Dr. James Taylor		
GMC code	1350799	GP code	20648
Practice name	Dalry Medical Practice (80217)		
Practice code	80217		

Practice address

Dalry Health Centre
50 Vennel Street
Dalry
KA24 4AF

Contact number(s)

Voice: 01294 832523
Facsimile: 01294 835771

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: Episodic pains at base of penis

Comment: The above 46 year old gentleman complains of episodic severe pains at the base of his penis on the left hand side for the past several months. This tends to come on with movement. He denies any particular problems with micturition or similar. He does have a past history of vasectomy and circumcision in 2005. Circumcision being performed for recurrent episodes of balanitis and irritation of foreskin. When I examined him today I am afraid I could detect no gross abnormality and I am not sure what this pain is but I would be grateful for your help. Yours sincerely Dr James A Taylor

Examinations and Investigations

Height:	167	-	
Weight(kg):	67	-	
BMI:	24.02	-	
Current smoker:		20-Oct-2011	
Alcohol consumption, 0 units/week:		20-Oct-2011	

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions

Description	Laterality	Modifier	Extension	Date of onset	Recorded Date
Anxiety states	-	-	-	10-Dec-2010	10-Dec-2010
Erectile dysfunction	-	-	-	26-Feb-2008	26-Feb-2008
Cause of overdose - deliberate	-	-	drank bottle of disinfectant & alcohol	21-Jul-2001	21-Jul-2001
Death of son	-	-	age 10 - alcohol overdose	18-Oct-1997	18-Oct-1997
Alcohol dependence syndrome	-	-	-	17-Jun-1997	17-Jun-1997
Depressed	-	-	-	05-May-1997	05-May-1997
H/O: deliberate self harm	-	-	stabbing to abdomen	05-Apr-1997	05-Apr-1997
Cause of overdose - deliberate	-	-	paracetamol x 24 & alcohol	07-Jan-1996	07-Jan-1996
Query H/O: asthma	Uncertain	-	no recent evidence of asthma	20-Apr-1988	20-Apr-1988

Past procedures

Description	Laterality	Modifier	Comments	Date performed	Recorded Date
Internal fixation of bone NEC	-	-	# zygomatic bone	07-Jul-2006	07-Jul-2006
Bilateral vasectomy for contraception	-	-	-	22-Apr-2005	22-Apr-2005
Standard circumcision	-	-	-	22-Apr-2005	22-Apr-2005

Upper Gastrointestinal endoscopy	-	-	reflux oesophagitis, gastric ulcer, gastritis	11-Oct-1999	11-Oct-1999
Helicobacter pylori test positive	-	-	-	11-Oct-1999	11-Oct-1999

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Trazodone Hydrochloride Tablets 150 mg	0403010X0AAADAD	28 TABLET	ONE TO BE TAKEN AT NIGHT	-	10-Nov-2011	42 Days	13-Dec-2011
Trazodone Hydrochloride Tablets 150 mg	0403010X0AAADAD	28 TABLET	ONE TO BE TAKEN AT NIGHT	-	13-Oct-2011	28 Days	13-Oct-2011

Clinical warnings

Smoking status

Alcohol consumption

Lifestyle risks

Exercise status: Not Known

Number per day ? (not known)

Units per day ? (not known)

Additional relevant information

Administrative information

Referred By:Registered GP

Social circumstances

Signature of referring doctor (or other professional) **Date**

CM/MD/468158

21 May 2002

A & E REVIEW CLINIC
20.5.02

Dr Magee
Gatehead Road
CROSSHOUSE

Dear Dr Magee

STEPHEN GALLOWAY (14.6.65) 11 CORSE AVENUE, SPRINGSIDE

DIAGNOSIS: INFECTED WOUND RIGHT RING FINGER

This 36 year old gentleman was reviewed in the A & E Clinic today. The wound at the base of his right ring finger continues to discharge pus and has opened up slightly. Wound swab confirmed a heavy growth of Staph. Aureus, sensitive to Flucloxacillin.

At this stage the wound has been redressed with Jelonet and he will be reviewed in the Orthopaedic Clinic in one week's time. In the interim he should continue with his Flucloxacillin.

Yours sincerely

DR C MCGUFFIE
CONSULTANT IN A & E MEDICINE

CM/MD/468158

17 May 2002

A & E REVIEW CLINIC
16.5.02

Dr Magee
Gatehead Road
CROSSHOUSE

Dear Dr Magee

STEPHEN GALLOWAY (14.6.65) 11 CORSE AVENUE, SPRINGSIDE

DIAGNOSIS: 1 INFECTED WOUND RIGHT RING FINGER, 2 SUPERFICIAL LACERATION TO THE DORSAL ASPECT OF THE LEFT RING, MIDDLE AND INDEX FINGERS

This 36 year old gentleman was reviewed in the A & E Clinic today. He had been admitted under the care of Orthopaedics 5 days previously with a laceration to the volar aspect of the right ring finger MCP, which he had sustained on glass. This had been explored in theatre, revealing no tendon damage and the wound had been sutured. He attended A & E with a probable infection of this wound and a second injury to the dorsal aspect of the left ring, middle and index fingers having been struck on the hand with a stick.

X-rays of the left middle finger showed no bony injury and the wounds were toiletted and dressed under local anaesthetic block.

Regarding the infected right ring finger wound, this was toiletted and dressed with Inadine. He was commenced on Flucloxacillin.

On review today the wound continues to appear infected. The remaining sutures have been removed and the wound re-dressed with Jelonet. Penicillin V has been added to the Flucloxacillin. The left finger wounds are healing well with no deficit of finger movements.

He will be seen for review in 3 days.

Yours sincerely

DR C MCGUFFIE
LOCUM CONSULTANT IN A & E MEDICINE

STA0849

AYRSHIRE AND ARRAN ACUTE HOSPITALS NHS TRUST

Crosshouse Hospital Discharge

95461

G.P. Adrian

Patient Details:

Surname: Galloway
First Name: Stephen
Address:

DOB: 10/6/65
Unit No: 468158
(or date of birth if no unit number)

Ward: 2A
Consultant: TAIT

Date of Admission:
Date of Discharge: 13/5/02
(or date of death)
Clinic Appointment:

Services Arranged: ☐ Home help ___ times week ☐ Meals on wheels ☐ District Nurse ☐ Other
Discharged to: ☐ Home ☐ Stay with relatives ☐ Other hospital ☐ Nursing home ☐ Other ☐ Died

Discharge Diagnosis (if admitted due to an injury include place of accident & site of injury)	If multiple Day Case admission, list dates of admission
1	
2	
4	
5	

Operations / Procedures
1
2 Lacerated hand → exploration
3
4

Discharge Medication (7 days supply will be dispensed unless otherwise stated by doctor)

For Pharmacy use

Drug Name and formulation	Dose	Frequency	Route	Duration (cont/stop)	Quantity and strength	Notes
Co-codamol	1	2DS/PRN	PO		32 × 8/500	
					8/2	

pharmacy date 13/5/02 | dispensed by SHH | checked by AH

Additional Information (e.g. awaiting histology or other results, patients progress)

A finished consultant episode letter will follow.

Signature _____

PRINT NAME E. Adrian Date 13/5/2002

N.B. DISCHARGE MEDICATION IS FOR INFORMATION ONLY. FAXED COPY HAS NOT BEEN CHECKED BY DOCTOR. ON RECEIPT OF HARD COPY, FAXED COPY CAN BE DESTROYED.

Ward Clerkess: _____ / Dictated: _____ / Typed: _____ / Signed: _____ / Mailed: _____

[redacted]

Otolaryngology

DEPARTMENT OF OTOLARYNGOLOGY

AO/SJS/0000468158

Consultant in Charge : P WARDROP

DR ADRAIN
THE SURGERY
GATEHEAD ROAD
CROSSHOUSE

Date : 24/07/2001
Dictated: 24/07/2001

Dear DR ADRAIN

STEPHEN GALLOWAY 14/06/1965 8 CARMEL DRIVE SPRINGSIDE

ADMITTED:21/07/2001 DISCHARGED: 21/07/2001

DIAGNOSIS:CAUSTIC OROPHARYNGEAL DAMAGE

OPERATION:

This patient was admitted following deliberate ingestion of 50 ml floral disinfectant (methylated spirits) and alcohol. Superficial oral mucosal damage was noted but no airway compromise. He was able to swallow saliva and fluids. He refused to stay for observation and denied suicidal intent. Psychiatry advice was sought and we were unable to detain him. Advice was given to seek help from yourselves for on-going depression secondary to marital problems. No ENT follow-up has been arranged unless a stricture develops.

No Followup required.

Yours sincerely

DR A OLIVER
SHO IN ENT SURGERY

DB/EMcK/468158

MAXILLOFACIAL SURGERY SERVICE
MR S HISLOP/ MR A T M CARTON

Direct Line ☎ 01563 577293
Fax No: 01563 577300
Appointments ☎ 01563 577069/577070

Dictated: 14.12.00
Typed: 21.12.00

Dr A Adrain
Crosshouse Clinic
Gatehead Road
CROSSHOUSE

Maxillofacial

Dear Dr Adrain

STEPHEN GALLOWAY, 8 CARMEL DRIVE, SPRINGSIDE. DOB: 14.6.65

The above named patient was referred to the Oral and Maxillofacial out patient clinic by our Accident and Emergency Department at Crosshouse Hospital. Stephen sustained an alleged assault on 9th December 2000, where he received some punches to the left side of his face. However, today he had minimal symptoms. He has some tenderness in the left side of his face and some discomfort when his teeth are in occlusion.

On examination there is nil of note and his occlusion is satisfactory and stable. I do not feel that he requires any treatment. However, I have advised him that he should seek the help of his General dental Practitioner.

I hope this update is of use.

Yours sincerely

Debbie Boyd
Maxillofacial Senior House Officer

Our Ref: AJ/DM/468158

Telephone Number: (01563) 577590 - Direct Line
Fax Number: (01563) 577973

MEDICAL/DIABETIC UNIT
DR A JAAP

06 December 1999
(Clinic: 25/11/99)

Dr Adrain
The Surgery
Gatehead Road
CROSSHOUSE

Dear Dr Adrain

RE: STEPHEN GALLOWAY, 41 MAIN ROAD, SPRINGSIDE (DOB: 14/06/65)

Stephen was appointed to my Clinic for follow-up by the staff in the Admissions Unit. He has been well since discharge and has no further symptoms, although unfortunately it appears that the fact that he was helicobacter positive was not communicated to you at this stage. I would advise that he only has eradication therapy if he develops any further symptoms.

Yours sincerely

ALAN JAAP
CONSULTANT PHYSICIAN

Medical

* not our patient 2 Dr Nicol, Kilmarnock. *

AYRSHIRE AND ARRAN ACUTE HOSPITALS NHS TRUST

Our Ref: AJ/DM/468158

Telephone Number: (01563) 577590 - Direct Line
Fax Number: (01563) 577973

MEDICAL/DIABETIC UNIT
DR A JAAP

06 December 1999
(Clinic: 25/11/99)

— phone p/care ✓ Now Registered with Dr Adrain, XH

Dr W Nicoll
The Surgery
5a Henrietta Street
GALSTON

Dear Dr Nicoll

RE: STEPHEN GALLOWAY, 41 MAIN ROAD, SPRINGSIDE (DOB: 14/06/65)

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Yours sincerely

ALAN JAAP
CONSULTANT PHYSICIAN

MEDICAL RECORDS
CROSSHOUSE HOSPITAL
13 DEC 1999
ROUTINE

[redacted]

Our Ref: AJ/DM/468158

Telephone Number: (01563) 577590 - Direct Line
Fax Number: (01563) 577973

MEDICAL/DIABETIC UNIT
DR A JAAP

06 December 1999
(Clinic: 25/11/99)

Dr W Nicoll
The Surgery
5a Henrietta Street
GALSTON

Dear Dr Nicoll

RE: STEPHEN GALLOWAY, 41 MAIN ROAD, SPRINGSIDE (DOB: 14/06/65)

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Yours sincerely

ALAN JAAP
CONSULTANT PHYSICIAN

Medical

[redacted]

North Ayrshire and Arran NHS Trust
Crosshouse Hospital Discharge

1766

G.P.

Patient Det...

XH 468158

Surname: GALLOWAY
First Nam: STEPHEN
Address: 41 MAIN ROAD
SPRINGSIDE
KA1? 3AN

DOB: 14/06/1965
Unit No: DR.4 NICOLL
(or date of bir 5A HENRIETTA ST
GALSTON
CHI

Ward: 3E
Consultant: MACPHERSON

Date of Admission: 10/10/99
Date of Discharge: 11/10/99
(or date of death)
Clinic Appointment: 6/52

Services Arranged: ☐ Home Help .....times a week ☐ Meals on wheels ☐ District Nurse ☐ Other
Discharged to: ☑ Home ☐ Stay with relatives ☐ Other Hospital ☐ Nursing Home ☐ Other ☐ Died

Discharge Diagnosis: DRUG OVERDOSE

Drugs Taken: ALCOHOL

Alcohol: ~ 1½ L VODKA.

Injury: ADMITTED WITH MAMATOMES

Treatment Given: DIAZEPAM FOR WITHDRAWL.

Psychiatric Opinion: NOT GAINED.

Discharge Medication (7 days supply will be dispensed unless otherwise stated by doctor)

For Pharmacy Use

Drug Name and formulation	Dose	Frequency	Route	Duration (cont/stop)	Quantity and Strength	Notes
ZOTON	30mg	OD	PO	CONT		4/52.
				pharmacy date.	dispensed by	checked by

Follow Up:

Signature: .....

PRINT NAME: ARCHIBALD JMS (p/1991) Date 11/10/1999

This letter constitutes a formal discharge summary. A further typed letter is not anticipated from the AMAU.

Ward Clerkess: ...../Dictated: ...../Typed: ...../Signed: ...../Mailed: .....

STA0849

AYRSHIRE AND ARRAN ACUTE HOSPITALS NHS TRUST

Crosshouse Hospital Discharge

05015

G.P.

Patient D: XH 468158

Surname: GALLOWAY STEPHEN
First Nam: 41 MAIN ROAD
Address: SPRINGSIDE
KA11 3AN

DOB: 14/06/1965
Unit No: DR W NICOLL
(or date of birth a ... number) 5A HENRIETTA ST
GALSTON
CHI

Ward: 3E
Consultant: MACPHERSON

Date of Admission: 12/10/95
Date of Discharge: 14/10/95
(or date of death)
Clinic Appointment:

Services Arranged: ☐ Home help ___ times week ☐ Meals on wheels ☐ District Nurse ☐ Other
Discharged to: ☐ Home ☐ Stay with relatives ☐ Other hospital ☐ Nursing home ☐ Other ☐ Died

Discharge Diagnosis (if admitted due to an injury, include place of accident & site of injury)	If multiple Day Case admission, list dates of admission
1 HIATUS HERNIA	
2 ALCOHOL EXCESS	
3	
4	XH
5	

Operations / Procedures
1 ENDOSCOPY - HIATUS HERNIA + ALCOHOL
2 GASTRIC ULCER
3 ~~+ DUODENAL ULCER~~
4

Discharge Medication (7 days supply will be dispensed unless otherwise stated by doctor) — **For Pharmacy use**

Drug Name and formulation	Dose	Frequency	Route	Duration (cont/stop)	Quantity and strength	Notes
ZOTON	30mg	BD	PO	CONT 4/52	28 x 30mg	

Incident Number CR011010029

formation

.PHEN GALLOWAY

der: 58y Old Male

28 RED-URN PLACE IRVINE,KA12 9BH

'1965

50854

Date: 10/06/2024

Incident Number: CR011010029

Incident Type: EMG

Incident Location: 28 REDBURN PLACE IRVINE, KA12 9BH

Scottish Ambulance Service

Presenting Complaint

AIN

Additional Comments

ll to 58yo sob/chest pain. O/a pt sat in chair alert and orientated. O/e pt widespread wheeze, o2 sats 90%, BP ension pt not on medication for this. struggling to catch breathe. Started on salbutamol 5mg 2220 hrs. Pt walked cle. Given Atrovent 500mg 2230hrs. Hydrocortisone 100mg exp 04/28 2235 via IM. Pt struggling for breath imol 5mg via neb 2254 hrs.pt started been unwell for 6x weeks and hasnt been able to get gp appt pt has been ing today and home and friend concerned so phone 999. ?pe ? Excerabation of copd/asthma. after gtn pts ain subsided and bp normal. Pt has an non productive cough. Base crackles with wide spread wheeze. yed to xhouse.

PATIENT ASSESSMENT

U Alert <C> No

Clear

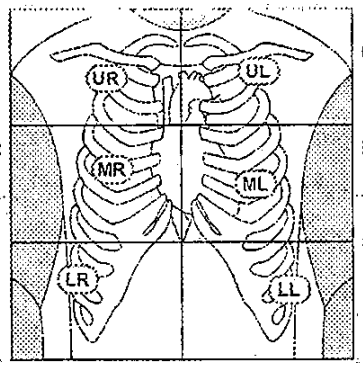
Breathing Adequately Yes | Chest Signs/Sounds | Cough

Respiratory Rate 28 | SPO2 90 | Oxygen Given Yes

Wheeze UR | UL Wheeze

Wheeze MR | ML Wheeze

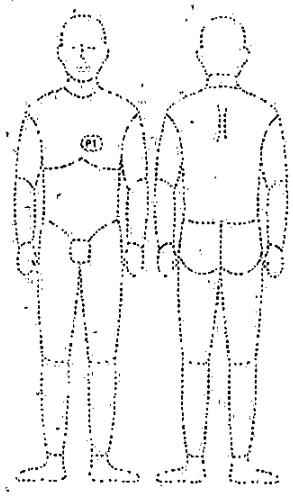
Wheeze LR | LL Wheeze



Pulse Rate	BP	Cap Refill	ECG Rhythm
121	145/113	<=2 Secs	Sinus Tachy

Rhythm	Arm	Central/Peripheral	ECG
Reg	Right	Peripheral	12 Lead

GCS	Eyes	Voice	Motor	PEARL
15	Spontaneously (4)	Orientated (5)	Obeys Commands (6)	Yes



Pain

ID	Body Part	Pain Scale
P1	Chest	4

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
22:30	121	28	145/113	90	<=2 Secs	15	Alert		37.1	7.9	Sinus Tachy				P123456S
22:27	125	28	167/113	90		15	Alert								P123456S

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
22:30	28 (3)		90 (0)	2	145 (0)	121 (2)	Alert (0)	37.1 (0)	7

Drugs

Time	Drug	Dosage	Units	Route	Drug Expiry Date	Pain Before	Pain After	CrewID
22:20	Salbutamol	5	mg	NEB				E1016962
22:30	Ipratropium Bromide (Atrovent)	500	mcg	NEB				E1016962
22:35	Hydrocortisone	100	mg	IM	04/2028			E1016962
22:45	Salbutamol	5	mg	NEB				E1016962
23:00	GTN	400	mcg	BUC				E1016962
23:10	GTN	400	mcg	BUC				E1016962
23:20	GTN	400	mcg	BUC				E1016962

HISTORY

AMPLE

Allergies	None
Medication	SEE ECS
Past Medical History	COPD, Asthma
MI	How Many:6
Last Eaten	>4 Hours Ago

Social History

Lives alone	Yes	Patient Occupation	PAINTER DECORATOR

Patients Gener. Appearance	Normal
Patient M . bility	Fully Mobile
Patient Communication	No Help Required

Patient Clinical Risk Factors	Smoker
Patient Enviromental Risk Factors	None Identified

MEDICAL

COPD

Assessment - Features	Cough, Wheeze

CLOSE RECORD

Treatment On Scene	Non-Emergency

Conveyance

Transport To Hospital	Normal driving	Pre-Alert	No

INCIDENT LOG

Time Call Received	21:40	Allocated	21:49	Mobile	21:49
First Resource On Scene		Crew On Scene	22:39	Crew Left Scene	22:39
Crew At Hosp	22:57	Receiving Hospital	CROSSHOUSE HOSPITAL	Clear Time	

Crew ID	Crew Grade	Driver
E9881812	Student Technician Level 4	YES
E1016962	Paramedic	NO
P123456S	Student Paramedic (BSc Placement)	NO

Crosshouse EMERGENCY DEPARTMENT

NHS Ayrshire & Arran

0853

A/E No: XH-24-028073-1
Date & Time: 10 Jun 2024 23:10

CHI No: 1406650854

Stephen GALLOWAY

Duty Consultant: DR MOHYUDIN DINGLE

Date of Birth: 14 Jun 1965
Age: 58 Years
Sex: M

GP:
V Bothwell
Frew Terrace Surgery
9 Frew Terrace
Irvine
KA12 9DY
01294 272326

Marital Status: Single

Address:
28 REDBURN PLACE
IRVINE
AYRSHIRE

KA12 9BH

Religion: None
Ethnicity: White Scottish

Next of Kin:
Hugh Galloway
Brother

Attendances
Last 12mths: 3
Total: 22

Phone Numbers:
Home: 07468337186
Mobile:

Special Case:

Employer/School:
Not at School

Accompanied by: Unaccompanied

Triage Time: 00:56 **Triage Nurse:** ~~Emma Lindsay~~ J Young **Triage Group:** Yellow

Resp Rate	O2 Sat%	PFR

Pulse	BP	E	M	V

Allergies: No Known Allergy

BMstix	NEWS	Temp	Weight

Visual Acuity
R:
L:

Pain Score Triage: 6

Triage details:
increasing sob and chest pain ? collapse today, sats 90, had nebs, hydrocortison, 1200 gtn
Treatment
NONE
Special Needs
NONE
Clinical Frailty Score:
Re-assess in 15 30 60 minutes

I give consent for details of my injury to be given to the Police.
Signed:..... 11/06/24

Against Medical advice I decline the treatment offered. I know this may affect my recovery.
Signed: ..... Witness: ..... Witness: .....

Disch A+E clinic Paed Tr. # Eye ENT Max Facial
Ward OP Ward IP.....

1406650854

Stephen Galloway CHI: 1406650854 A/E No: XH-24-028073-1

Drug	Dose	Route	Time/Freq	Signature	Given By	Date	Time
Amoxicillin	1000mg	PO	STAT		J. Young	11/6/24	0420

Kardex started? ☐ *Further drug prescriptions on Drug Kardex, do not print further ED Cards*

PVC 1	Size/Colour	Location	Initials	PVC 2	Size/Colour	Location	Initials

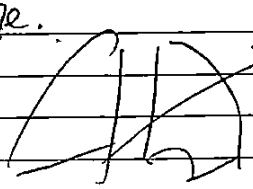
	Device	Flow Rate l/min	%O2 for Venturi	Target SpO2	Prescribed by	Started by	Stopped by
Oxygen							
Changed to							

Clinician Name: Jade Burns
Grade: CMP

Date: 11/06/2024
Time: 0420

58 M w collapse episode @ home. No prodrome / strenuous activity. Reports 2x of these per week. [illegible] Also c/o SOB. Usually has mod SOB + dry cough with COPD. No chest pain / palpitations.

O/E.



O2 sats 94%
HR 115

Inf
Medical collapse.
ECOPD / CAP
O2 demand.

Bloods.
Inflam. markers
CXR 2pm.

Plan

Aim 94%>
Amoxiclav
CXR
Bloods
Recess
Mediv.
Telemetry

CROSSHOUSE EMERGENCY DEPARTMENT

1406650854

HCR NO:	
CHI:	1406650854
Surname:	**GALLOWAY**
Forename:	**Stephen**
Sex/DoB/Age:	Male / 14 Jun 1965 / 58 Years
Address:	28 REDBURN PLACE IRVINE AYRSHIRE KA12 9BH

I.V. Therapy and Prescription Sheet

	DATE	FLUID(USE BLOCK LETTERS) / ADDITIVE DRUG	Vol (ml) / Dose(mg)	Route of Admin.	Dur.of Admin*	SIGNATURE	Serial No. / Batch No.	Time Begun	Given By / Added By
A	11.06	0.9% NaCl	~~500~~ 1000	IV	4h		232085 HH	0445	JMcG
B									
C									
D									
E									
F									
G									
H									
I									
J									
K									
L									
M									
N									
O									

RATE OF FLOW (Drops/Min.) = VOL. OF FLUID (ml) X 15 / Duration (Mins.) (1ml = 15 drops)

Approximate Rate for 500ml: 1h = 120 Drops/min; 4hr = 30 Drops/min; 6h = 22 Drops/min; 8hr = 15 Drops/min

6.62

PLEASE FILL OUT FLUID BALANCE CHART OVERLEAF

CROSSHOUSE EMERGENCY DEPARTMENT

CHI: 1406650854

Fluid Intake and Output Chart

DATE						YESTERDAY'S BALANCE			
	INTAKE (ml)					OUTPUT(ml)			
	ORAL	INTRAVENOUS		OTHER		URINE	STOMACH	BOWEL	DRAINAGE
Time	Amount	Amount	Nature	Amount	Nature	Amount	Amount	Amount	Amount
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
1									
2									
3									
4									
5									
6									
7									
TOTAL						(a)	(b)	(c)	(d)

INTAKE =	ml	(e) Insensible loss* = OUTPUT (a + b + c + d)	ml
BALANCE =	ml		

*Average Adult = 600ml +100ml per each 0.5° C temperature elevation

Crosshouse Emergency Department

Name: Stephen Galloway **CHI No: 1406650854**

Nursing Notes

Date/Time		Signature
11/6/24 01:10	B/BA worsening SOB/ chest pain ? collapse had hebs, hydrocort + PO0 given with SAS. News as charted ecg and bloods ✓	AYoung
0325	CXR ✓ - Rpt news 4 sats 91% on air commenced on 2 L O_2 via nasal cannula, aim sats >94%. HR 108.	ECampbell
0440	IV ACCESS ✓ IV amox ✓ IVF CRP 200 referred to medics	AYoung
0630	News 4. awaiting bed CAU	A Young
0845	Care taken over by dayshift	
	News 4 - O_2 therapy and sats 94%	
	Breakfast accepted	Connie Wilson Staff Nurse Emergency Departme
	No nursing assistance required at present	
11/06/24 11:30	- patient advised needed to leave department to go to bank. Advised against medical advice. - Patient wants to leave and return, advised not with medical monitoring & care and if leaves will have to represent. - patient adamant leaving	

Crosshouse Emergency Department

Name: Stephen Galloway **CHI No: 1406650854**

Nursing Notes		
Date/Time		Signature
	Signed Yellow Card and witnessed - Cannula removed - meds addressed patient away didn't wait to speak to medics - advised initial assessment — (RG)	

CROSSHOUSE EMERGENCY DEPARTMENT

Name: Stephen Galloway **CHI No:** 1406650854
Address: 28 REDBURN PLACE IRVINE AYRSHIRE KA12 9BH
Arrival Date/Time: 10 Jun 2024 23:10

Nurse Signature on initial assessment: J Young Print Name: J Young

Triage Comments:	increasing sob and chest pain ? collapse today, sats 90, had nebs, hydrocortison, 1200 gtn
Past Medical History	

DNACPR	Y	N/A	AWI	Y	N/A	Insulin	Y	N/A	On Anticoagulant?	Y	NA

Allergies		Medications given by Paramedics	

Nursing Notes: Care taken over by

Date/Time	Name Printed	Signature
11·6·24 0840	C WILSON	

Name band in situ					Y	N	Patient prepared for exam & clothes bagged	Y	N
ECG	1st	✓	2nd		Other		Valuables with patient:	Y	N
IV Access					Y	N	*If yes, please specify action taken*		
PVC Size/Colour:	Pink						Relative/Carer/Next of kin present:	Y	N
PVC Location:	(R) ACF						Name: Hugh	Relation: Brother	
Inserted by:	E.D.						Contact Number:		

Blood samples		Y	N	Language, visual or hearing difficulty:	Y / N/A
Blood gases		Y	N	*If yes, please specify:*	
Blood cultures		Y	N	Interpreter required:	Y / N/A
PCR Test		Y	N	*If yes, please specify:*	
Radiology		Y	N	Package of Care?	

Screening tools Assessment	Date 11/6/24 Time 0110		Date Time			Date 11/6/24 Time 0110		Date Time	
SEPSIS SCREEN	Y	N	Y	N	Adult Support & Protection	Y	N	Y	N
FAST Score	Y	N	Y	N	McKillop Tool	Y	N	Y	N
AAMAWS commenced	Y	N	Y	N	Child Protection/Wellbeing	Y	N	Y	N
Big Six (hip fracture	Y	N	Y	N					

Mobility	Bed Rest		Independent	✓	Assistance/walking aid, specify:

If **YES** to any Falls Risk Assessment questions complete the safety intervention section. Repeat if the patient has a fall, is taking risks, has a change in condition/cognition.

Falls risk Assessment	DATE 11/6/24 TIME 0110		DATE TIME		**Safety interventions**	DATE 11/6/24 TIME 0110		DATE TIME	
High risk of falling based on your clinical judgment?	Y	N	Y	N	Nonslip socks provided?	Y	N	Y	
Fall in the last 6 months (including this admission)?	Y	N	Y	N	Behaviour monitoring chart	Y	N	Y	
Cognitive impairment/possible delirium?	Y	N	Y	N	Supervision required in bathroom/commode?	Y	N	Y	
Risk taking/attempting to walk alone/unsteady?	Y	N	Y	N	Falls warning sign on whiteboard/symphony	Y	N	Y	
Does the patient/their relative have a fear/anxiety about falling?	Y	N	Y	N	Bed in Visible area.....	Y	N	Y	

Crosshouse Emergency Department

Name: Stephen Galloway **CHI No: 1406650854**

ED 4AT Delirium Assessment: Complete / update for all Patients over 65, anyone of any age, with a cognitive impairment/previous delirium, current hip fracture, acute illness or SQID positive (is your patient more confused or drowsy than normal?) N/A?	✓		
ALERTNESS: This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient, if asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating. Circle relevant number below			
Date			
Time			
Normal (fully alert, but not agitated, throughout assessment)	0	0	0
Mild sleepiness for <10 seconds after waking, then normal	0	0	0
Clearly abnormal	4	4	4
AMT4: Age, date of birth, place (name of the hospital or building), current year			
No Mistakes	0	0	0
One Mistake	1	1	1
Two or more mistakes	2	2	2
ATTENTION: Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "What is the month before December?" is permitted.			
Achieves 7 months or more correctly	0	0	0
Starts but scores < 7 months / refuses to start	1	1	1
Untestable (cannot start because unwell, drowsy, inattentive)	2	2	2
ACUTE CHANGE OR FLUCTUATING COURSE: Evidence of significant change or fluctuation in: alertness, cognition, other mental function (e.g. paranoia, hallucinations) over the last 2 weeks and still evident in the last 24 hours.			
No	0	0	0
Yes	4	4	4
Total			
Signature			
4AT Score of 4 and above: Possible delirium +/- cognitive impairment (Complete the TIME bundle below) 4AT Score of 1-3: Possible cognitive impairment 4AT Score of 0: Delirium or severe cognitive impairment unlikely (but delirium still possible if [4AT] incomplete)			
TIME BUNDLE: Complete the TIME bundle if the **4AT Score if 4 and above.**			
Date			
Time			
T Think possible triggers for delirium applicable	Use Codes: Y-Yes N-No NA-Not		
Is the patient in pain? (start pain chart, review analgesia)			
Is the patient constipated or at risk of constipation? (Commence bowel chart and aperients).			
Is the patient in urinary retention? (Palpate bladder/scan)			
Is the patients' oral intake sufficient to prevent dehydration? (Encourage hourly fluids start FBC)			
Could any drugs trigger delirium? (Doctor to review medication)			
Blood sugar, high or low?			
Is there a history of alcohol intake/drug abuse? (Intoxication or withdrawal, GMAWS/drug misuse)			
I Investigate			
Record NEWS			
Screen for infection (and consider urinalysis)			
Take bloods and ensure ECG/appropriate imaging			
M Management: Diagnose causes & initiate treatment			
Document diagnosis of delirium			
Document potential causes of delirium			
Document treatment plan			
E Engage and Explore			
If appropriate, explain diagnosis of delirium to patient/family/carers and provide delirium leaflet			
Engage with patient/family/carers. ("What matters to me"/ "Getting to know me")			
Does the patient have capacity to consent to care? (In no, complete AWI document)			
Signature:			

Crosshouse Emergency Department

Name: Stephen Galloway **CHI No: 1406650854**

Preliminary Pressure Ulcer Risk Assessment (PPURA), update daily:
Mobility: Patient requires assistance to mobilise/change position. Continence: Patient has continence issues which may/has compromise/d skin. Nutrition: Patient appears malnourished and/or unable to eat/drink. Skin: Patient has a pressure ulcer/skin is compromised (medical devices, neurological deficit, medication, co-morbidities)
If YES to any of above, activate care plan below.

Date	Time	Mobility		Continence		Nutrition		Skin		Sign
11/6/24	0110	Y	(N)	Y	(N)	Y	(N)	Y	(N)	
		Y	N	Y	N	Y	N	Y	N	

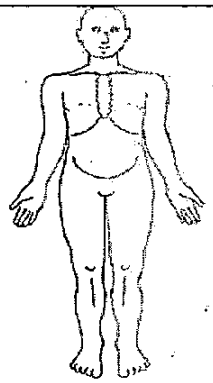
Pressure Prevention Care Plan

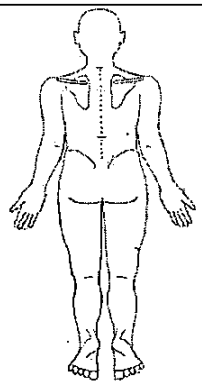
Patient is **at risk** of developing a pressure ulcer? Y ☐ N ☑

Patient **has** a pressure ulcer? Y ☐ N ☑ **(If yes to either, initiate care plan below)**

Date	Initial	Nursing intervention	Discontinued	Date/Time	Sign
		Ensure regular repositioning is carried out and documented on Care and Comfort round chart			
		The patient should not sit out of bed for longer than 2 hours without being repositioned (for acutely ill patients return to bed for a minimum of 1 hour)			
		Use sliding sheets to prevent shear and friction during movement in bed and record use in care round. Sliding sheets should not be left under the patient.			
		If the patient is incontinent use a PH balanced cleanser to clean and barrier products to protect as per: 'Scottish excoriation and moisture related skin damage tool'.			
		Move patient to bed with foam redistributing mattress. Initiate bedrail risk assessment and follow algorithm			
		Encourage a healthy, well-balanced diet and adequate fluid intake.			
		If the patient has a grade 2 or above pressure ulcer a wound assessment chart is required. Available from AthenA			
		Plan of care discussed and agreed with the patient as appropriate. Evaluate care in the nursing records.			

Date/Time	Location of ulcer	Grade of ulcer	Signature





Crosshouse Emergency Department

Name: Stephen Galloway **CHI No: 1406650854**

ED Care Round Checklist:
Frequency to be prescribed in relation to the patient's greatest need
To be completed by the member of staff delivering care. If unable to use the nurse call bell prescribe care and comfort at one hourly

Date /Time	Name	Designation	Signature	Circle frequency prescribed
11/6/24 0410	J Young	SN	J Young	1 2 3 4 12
11-6-24 0840	C WILSON	SN	C Wilson	1 2 3 4 12
				1 2 3 4 12

Use the following codes: **Y** – Yes **N** – No **NA** – not applicable **NT** – No Thanks
S - Sleeping **O** – Out of department **I** - Independent

	Date								
	Time								
	THINK DELIRIUM: Is the patient more confused or drowsy than normal? *(if yes escalate and update 4AT)*								
	PAIN: ASSESS AND ADDRESS. Is the patient distressed and/or in pain? *If yes inform nurse in charge*								
S	**SKIN INSPECTION** Pressure areas checked? (Y/N)								
	N normal briskly reactive (1-2 secs), **SR** slowly reactive (3-6 secs) **D** discoloured **U** pressure ulcer **M** moisture **E** excoriation								
	Cushion/heel protector appropriate: **Y**-Yes **N**- No Type								
K	**Keep moving** Has the patient changed position or walked?								
	Bed: **R**:right side **L**: left side **B**: back **I**: independent								
	Chair: **W/ST**: Assisted to walk/stand **I**: independent								
	Sliding Sheet used								
I	**Elimination**: Patient offered the toilet?								
	I independent **A** assistance given **IC** incontinence (urine/faeces) **BO** Bowels open **C** Catheter								
N	**Food/Fluid and Nutrition** Fasting **F** Nil by mouth **NBM**								
	Drink taken								
	Food, snack or supplement taken								
	Oral hygiene carried out								
	Environmental check: is the nurse call bell to hand, area clutter free, belongings within reach								
	Is the trolley/bed at the lowest level								
	Information: is there anything I can help you with? Inform patient of return time								
	Escalation required to nurse in charge?								
	Move bed/trolley to visible area if taking risks								
	Patient stay > 12 hours? - Consider moving to a bed								
	If patient on bed, complete a bedrail risk assessment								
	Initials								
	Designation								

NHS Ayrshire & Arran

Acute Assessment Proforma

GALLOWAY Stephen
28 REDBURN PLACE, IRVINE
KA12 9BH
DOB: 14/06/1965

Date: 11/6/24 Time: 0930

Referral source: ED Consultant: SHEPHERD

Presenting Complaint and relevant History

58M Collapse

Collapsed after getting home from pub yesterday

Does not recall exactly what happened as had been drinking

Does not recall any preceding symptoms

Witnessed by friend – no seizure activity

No injuries

Has had similar collapses for years – is not sure if ever investigated or not

Has also felt more SOB than usual – normally able to walk ~40 yards; now SOB on minimal exertion

No chest pain

Has cough – struggling to expectorate much

Past Medical History

COPD

Alcohol excess

Systems Enquiry

No GI upset

No urinary Sx

Family History

Social History

Employment:

Driving status:

Lives with: Alone

Recent Travel:

Mobility: Independent

Functional Capacity:

Family Support:

Smoker: Roll-up

Home Care:

Alcohol (units/wk): 7 200 / week

Staple Med Rec Here **Medication History and Multidisciplinary Medicines Reconciliation**

Must be started by the admitting Clinician and reviewed by the pharmacist within 24 hours

Please print ECS in the medicines reconciliation format and take medication history from the patient or relative & do medicines reconciliation and staple to this page. If not possible, use table below.

Allergies & Adverse reactions:→

Medicines / Substance	Reaction

Details of Medicines obtained from							
PODs		ECS		Nursing Home Chart		Recent IDL	
Patient		GP Letter		Community Pharmacist			
Relative/Carer		Phone call to GP		Other (please specify)			

Medicine	Dose	Frequency	Continue	Amend	Suspend	Stop	Comments
Salbutamol	2P	PRN					
Tadalafil	5mg	OD					
Thiamine	100mg	TDS					
Amitryptyline	75mg	ON					
Spiriva	2.5mg	OD					
Lansoprazole	30mg	ON					

Are you satisfied this medication history is complete and accurate? YES ☐ NO ☐

If NO what further action is necessary (Contact GP etc.) ..... Tick when resolved ☐

Doctor/ANP signature ..... Date/Time ..... Beep No .....

Pharmacist Signature..... Date/Time ..... Beep No .....

General Examination and Cognitive Assessment:

BP - Lying: 170/95 Standing (1 min): (3 min): Pulse: 108

Temp: 36° RR: 16 SpO_2: 95 % on air or FiO_2: 2L **NEWS:**

4AT score: Is AWI needed? Yes/No Clinical Frailty Score:

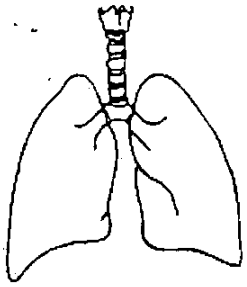
Other findings (Skin, Joints, Calves, etc.):

Cardiovascular Examination

Pulses: UP. Heart rate/rhythm: Reg Heart sounds/Murmurs: I + II no

JVP: Pedal oedema: Heaves / Thrills:

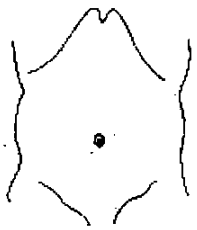
Respiratory Examination



Crackles RLZ

PEFR:

Abdominal Examination



SNT

Bowel sounds:

PR exam:

Neurological Examination: GCS: 15 /15 (E___/4, M___/6, V___/5)

Gait: Cranial Nerves:

Meningism:

Cerebellar signs: Fundoscopy:

	RUL	LUL	RLL	LLL
Pronator drift			-	-
Tone				
Power				
Reflexes				
Sensation				
Co-ordination				
Plantar reflexes				

Investigations:

Relevant Bloods:

WCC 14·5 U+E N
CRP 205 LFT N

CXR: Clear

ECG: Sinus tachy
QTc 462 ms

ABGs:

Urinalysis: Leucocytes Nitrites Protein Blood Glucose Ketones

Differential Diagnoses / Problem list & Treatment Plan

Acute issue appears to be
① Infection – URTI most likely source
② Alcohol dependence / risk of withdrawal

Longstanding changes for years
– may all be due to alcohol excess

Plan Abx for URTI
D-dimer ± CTPA + UMOH
Pabrinex
AAMAU,
Cardiac monitoring
E+ JBP
Allocate general

Medicine Reconciliation completed	☐	Is there an existing anticipatory care plan/KIS? Yes/No	
VTE Prophylaxis assessed & prescribed	☐	Treatment Escalation Plan (TEP) considered/filled	☐
Antibiotics as per microbiology policy	☐	DNACPR considered/documented ☐ Not Applicable	☐

Name & Grade (ID stamp):
Signature:
Page no.: ~~30~~ 3962

Location: ED
Time: 1600

Further review as needed: Date: **Time:** **Location:** **Signature:**

Venous thrombo-embolism (VTE) prophylaxis risk assessment tool

Do Not Use in Acute Stroke

Risks for thromboembolism (tick if apply)

- ☐ Age >60 years
- ☐ Active cancer or cancer treatment
- ☐ Any significant medical illness
- ☐ Critical care admission e.g. HDU/ITU
- ☐ Dehydration
- ☐ Known thrombophilia
- ☐ Obesity (BMI > 30)
- ☐ Personal history or first degree relative with a history of VTE
- ☐ Pregnancy or < 6 weeks post-partum
- ☐ Significantly reduced mobility for 3 days or more
- ☐ Use of hormone replacement therapy
- ☐ Use of oestrogen-containing contraceptive therapy

1 or more Risk Factors

No Risk Factors ☐

No prophylaxis required
Review decision 3x weekly

Contraindications to Dalteparin (tick if apply)

- ☐ **Lumbar Puncture/Epidural/Spinal Anaesthesia** in previous 4 hours *or expected within next 12 hours*
- ☐ Any other procedure with high bleeding risk expected during this admission (including neurosurgery, spinal or eye surgery)
- ☐ Active bleeding
- ☐ Acute stroke
- ☐ Acute gastro-duodenal ulcer
- ☐ Thrombocytopaenia (Platelets <75x10^9/L)
- ☐ Uncontrolled hypertension >230/120 mmHg
- ☐ Any other concern (document in case notes)
- ☐ Acquired bleeding disorders e.g. acute liver disease
- ☐ Previous Heparin Induced Thrombocytopaenia (HIT)
- ☐ Concurrent use of any other anticoagulants(e.g. Warfarin)
- ☐ Untreated inherited bleeding disorders

Any Contraindications ☐

Do not prescribe LMWH
Consider Anti Embolic stockings.
Review decision 3x weekly

No Contraindications ☐

Please prescribe Dalteparin 5000 units subcutaneously once daily ☐

FBC (platelets) to be checked on day 0 and day 1. **Review VTE prophylaxis 3 x weekly**

NB. Reduction of prophylactic dose NOT required for patients with renal impairment (eGFR <30 ml/min)

Discussion with patient regarding risk of VTE & risks/benefits of LMWH ☐

☐ **Suspected DVT or Pulmonary Embolism** should receive treatment dose Dalteparin, until excluded.

NB. Treatment dose LMWH should be reduced by 20% if eGFR <30 ml/min – see ADTC 75

Pneumonia

CURB65 Score

C	Confusion (4 point AMT ≤ 3)	1
U	Urea >7 mmol/L	1
R	Respiratory Rate >30/min	1
B	Systolic BP <90 mmHg	1
65	Age greater than 65	1

Score 0 - 1 = Mild = PO Abx
Score 2 = Moderate = IV Abx
Score ≥ 3 = Severe = IV Abx

Always refer to local antibiotic policy

Use clinical judgement (e.g. bilateral pneumonia, degree of hypoxia).

Upper GI Bleed

Glasgow Blatchford Score

Criterion	Male	Female	Score
Hb (g/dL)	120-130	100-120	1
	100-120	-	3
	<100	<100	6
Urea (mmol/L)	6.5 - 8		2
	8- 10		3
	10 - 25		4
	>25		6
Systolic BP	100 - 109		1
	90 - 99		2
	< 90		3
Pulse ≥ 100	Present		1
Melaena	Present		1
Syncope	Present		2
Liver	Present		2
CCF	Present		2

Score 0 – 1; consider early discharge
Score >6 = 50% likely need intervention

TIA Assessment

$ABCD_2$ Score

Age > 60	1
BP >140 / 90	1
Speech disturbance	1
Unilateral weakness	2
Duration 10-59 min	1
≥ 60 min	2
Diabetes	1

Score <4; start aspirin 300mg.
Score ≥4; start aspirin 300mg & specialist assessment <24h; carotid doppler / brain imaging.

Improving Sepsis Survival

If NEWS ≥ 5, suspect sepsis and ensure IV antibiotics are given within 1 hour as per local guidelines.

Anion Gap

$= (Na^+ + K^+) - (Cl^- - HCO_3^-)$

Used to assess the contribution of unmeasured anions to acidosis. Normal range 10-20 mmol/L.

Pulmonary Embolism

Two-level PE Wells sore

Clinical symp/signs of DVT	3
Alternative diagnosis less likely	3
Heart rate >100 bpm	1.5
Immobilisation>3d/Surgery<4wks	1.5
Previous DVT/PE	1.5
Haemoptysis	1
Malignancy(on Rx/Rx,6months)	1

Score > 4 – PE likely
Score ≤ 4 – PE unlikely

Alcoholic Hepatitis

Glasgow Alcoholic Hepatitis

Age	< 50	1
	≥ 50	2
WCC	< 15	1
	≥ 15	2
Urea	<5	1
	≥ 5	2
INR	< 1.5	1
	1.5 - 2	2
	>2	3
Bilirubin	< 125	1
	125 - 250	2
	> 250	3

If total > 9, consult Gastro about steroids

Maddrey's score

= (4.6 x (PT test - control))
+ Bilirubin ÷17
(If total >32, consider steroids)

Oxygen Therapy

BTS Guidance

No risk of chronic hypercapnic respiratory failure:
Aim sats 94 – 98%
If sats < 85% initially use trauma mask 15L

Risk of chronic hypercapnic respiratory failure/COPD.
Aim sats 88 – 92%
Initially use Venturi mask 28%

Deep Vein Thrombosis

Modified Wells

Active malignancy (or Rx ≤ 6mo)	1
Paralysis or plaster	1
Bedridden >3/7	1
Vein tenderness	1
Entire swollen leg	1
Difference in calf >3cm	1
Unilateral oedema	1
Previous DVT	1
More likely diagnosis	-2

Score < 2, low risk, for D-dimer
Score ≥ 2, high risk, for Doppler ultrasound

Ambulatory PE management

PESI Score

Variable	Points
Age	1/year
Male	10
Cancer	30
Heart failure	10
Chronic lung disease	10
Heart rate >110/min	20
Systolic BP <100 mm Hg	30
Respiratory rate ≥ 30/min	20
Body temperature < 36°C	20
Altered mental state	60
SaO2 <90%	20

PESI score predicts 30-day all-cause mortality as follows:

			Risk
Class I	PESI <65	0-1.6%	Very low
Class II	PESI 66-85	1.7-3.5%	Low
Class III	PESI 86-105	3.2-7.1%	Moderate
Class IV	PESI 106-125	4.0-11.4%	High
Class V	PESI >125	10-24.5%	Very high

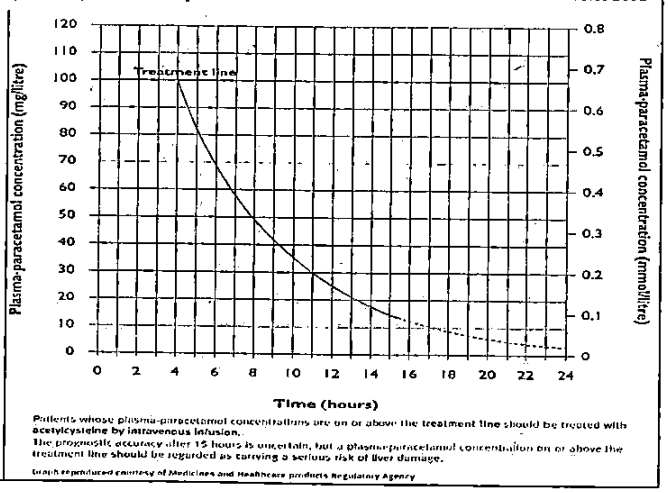
Non-Valvular AF anticoagulation

CHA_2DS_2 Vasc

Heart Failure	1
Hypertension	1
Age 65 - 74	1
Age ≥ 75	2
Diabetes	1
Previous TIA or stroke	2
Vascular disease	1
Female	1

If ≥1, for Warfarin
Consider LMWH & novel oral anti-coagulants.

Refer to SNAP protocol for Paracetamol OD treatment



Patients whose plasma-paracetamol concentrations are on or above the treatment line should be treated with acetylcysteine by intravenous infusion.
The prognostic accuracy after 15 hours is uncertain, but a plasma-paracetamol concentration on or above the treatment line should be regarded as carrying a serious risk of liver damage.

Graph reproduced courtesy of Medicines and Healthcare products Regulatory Agency

Is patient frail, sick and at risk of deterioration/dying? **Yes ☐ No ☐**

If **yes**, please discuss treatment escalation plan with patient and/or relative, and complete Treatment Escalation Plan (TEP)

TEP completed? Yes ☐ No ☐

DNACPR considered / completed? Yes ☐ No ☐ N/A ☐

Write or attach label

CHI No .....

Surname: .....

Forename: ..... Sex: .....

DOB:

Consultant Review: Date: Time: Location:

Specialty Allocation:	**Discharge anticipated today:** Yes ☐ No ☐
Med. Rec. ☐ VTE prophylaxis ☐ AWI ☐	**EDD:** **or** <24hr 24-72 hrs >72 hrs
Consultant Signature:	
Name (ID Stamp):	

RADIOMETER ABL90 SERIES

ABL90 CROSSHOUSE A/E GREEN I393-092R0 01:21 11/06/2024
PATIENT REPORT Syringe - S 65uL Sample # 21350

Identifications

Patient ID	999
Patient last name	galloway
Patient first name	stephen
Sample type	Venous
Temperature	37
$FO_2(I)$	21.0 %

Blood gas values				
	pH	7.386		[7.350 - 7.450]
	pCO_2	5.64	kPa	[4.27 - 6.40]
↓	pO_2	3.89	kPa	[11.1 - 14.4]
	cH^+_c	41.1	nmol/L	[-]
Oximetry values				
	ctHb	137	g/L	[115 - 178]
↓	sO_2	51.5	%	[94.0 - 98.0]
↓	FO_2Hb	50.4	%	[94.0 - 98.0]
	FCOHb	1.8	%	[0.0 - 3.0]
↑	FHHb	47.4	%	[0.0 - 2.9]
	FMetHb	0.4	%	[0.0 - 1.5]
Electrolyte values				
	cK^+	3.7	mmol/L	[3.5 - 5.1]
	cNa^+	136	mmol/L	[136 - 145]
	cCa^{2+}	1.21	mmol/L	[1.15 - 1.33]
	cCl^-	98	mmol/L	[-]
Metabolite values				
↑	cGlu	7.3	mmol/L	[4.1 - 5.6]
↑	cLac	3.5	mmol/L	[0.2 - 1.8]
	Hct_c	42.0	%	[36.0 - 53.0]
Oxygen status				
	ctO_{2c}	4.3	mmol/L	
	$p50_c$	3.80	kPa	
Acid-base status				
	$cBase(Ecf)_c$	0.4	mmol/L	
	$cHCO_3^-(P,st)_c$	23.5	mmol/L	

Notes

↑	Value(s) above reference range
↓	Value(s) below reference range
c	Calculated value(s)

Solution pack lot: BW-13 Sensor cassette run #: 2958-79
Printed 01:21:46 11/06/2024

NHS Ayrshire & Arran Clinical Notes

NHS Ayrshire & Arran

Demographics			
Forename	Stephen	CHI	1406650854
Surname	Galloway	Telephone Number	
DOB	1965-06-14	Sex	Male
Address	28 Redburn Place Irvine Ayrshire		

Date	2-Jun-2021	Clinician	Margaret Allison

Clinical Note

Day 14 post op surveillance call made.

No Covid 19 symptoms reported.

No other issues raised.

Date	26-May-2021	Clinician	L Peggie

Clinical Note

Day 7 post op surveillance call made.

No Covid 19 symptoms reported.

No other issues raised.

Data linkage consent verbally agreed.

Patient agrees to further contact if required.

ENDOSCOPY PRE-ASSESSMENT FORM

Date of pre-assessment	12/5/21	Name: Stephen Galloway Address: 28 Redburn Place, Irvine, KA12 9BH CHI: 1406650854 Tel: 07468337186 GP: TG Miller (4506627) Clinic 4 Lanfine Way (8069
Procedure/Date/Time Endoscopist	19/5/21 @ 1420 OGD AST	

Telephone Screening SCOTS Criteria completed CV19 pandemic 3 days isolation **(covid test:16 /5 /2021)**
1st Phone Call .

1. Symptoms: Do you have any of the following symptoms?
   - Fever
   - Persistent cough
   - Loss of taste and smell
   - Nausea and vomiting (new onset)
2. Contact: Have you had contact with anyone who has these symptoms or has tested positive for CV19?
3. Occupation: nil
4. Travel: Have you travelled more than recommend distance in the last 2 weeks?
5. Shield: Have you been advised to shield? no

Reason for procedure:
Follow up from admission with malaena

Will you have a responsible adult to take you home and stay with you for 24 hours?	YES	T spray

Medical History	**Comments**
Pacemaker/ICD Cardiac	no
Diabetes	no
Liver	alxs
Hypertension	no
Blood disorders	no
Renal	no
Respiratory	COPD

ENDOSCOPY PRE-ASSESSMENT FORM

Surgery	no
Glaucoma	no
Stroke	no
Epilepsy	no
Joint Problems	Arthritis in shoulders
Pregnancy	no
Other Health problems	Self inflicted injuries, ETOH, anxiety, depression
Allergies	no
Social History	**Comments**
CJD (Creutzfeldt–Jakob disease a fatal degenerative brain disorder.)	no
Special Requirements translator or mobility?	no

Current Medications – check for anticoagulation		
Ventolin inh		
Spiriva inh		
thiamine		
lansoprazole		
amitriptyline		

Problem/Action - highlight any issues concerning vulnerability, background, culture.
No one at home so t spray only

Checklist	**Comments**
Procedure explained	Yes
Risk and complications discussed	Yes
Consent process started	Postal
Special instructions	fasting
Fit for procedure	yes
Medical opinion requested/outcome	

Print Name of assessor: R Clark

-30 98%, 16RR, 88BPM, 36.4, 160/96.

10/12/2023 Incident Number: CR010251604

Patient Information

STEPHEN GALLOWAY

Age/Gender:	58Y Old Male
Address:	28 REDBURN PLACE IRVINE,KA129BH
DOB:	14/06/1965
CHI:	
Ethnicity:	White Scottish

Date:	12/10/2023
Incident Number:	CR010251604
Incident Type:	EMG
Incident Location:	136 DICKSON DRIVE IRVINE, KA12 9HD

Scottish Ambulance Service

Presenting Complaint

CHEST PAIN

Additional Comments

AS1 call to 58yom complaining of upper central chest pain that has been ongoing since discharge from hospital 2/7 ago. Pt describes the pain as burning in nature, non radiating with no associated symptoms. O/A pt lay on sofa, alert, conscious. Intoxicated ++ O/E HTN, all obs within normal parameters acvpu alert A- patent, self maintained B- nil cyanosis, nil increased WOB, nil cough, nil haemoptysis C- nil oedema, ongoing chest pain, ECG NSR ischemic. D- FAST neg, perrla, nil vomiting E- no other noted injuries or illness Plan- due to ongoing chest pain and previous cardiac history pt happy for conveyance to xhouse ED for further assessment. Pt comfortable on route

PATIENT ASSESSMENT

ACVPU Acute Confusion

<C> No

A Clear

B Breathing Adequately: Yes | Respiratory Rate: 16 | SPO2: 98

Oxygen Given: No

C

Pulse Rate	BP	Cap Refill	ECG Rhythm
91	170/116	<=2 Secs	Sinus Rhythm

Rhythm	Arm	Central/Peripheral	ECG
Reg	Right	Central	12 Lead

D

GCS	Eyes	Voice	Motor	PEARL
15	Spontaneously (4)	Orientated (5)	Obeys Commands (6)	Yes

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
21:47	99	17	166/114	97	<=2s	15	Alert		36.4	6.1	Sinus Rhythm				P121413S
21:40	91	16	170/116	98	<=2 Secs	15	Acute Confusion		36.4	6.1	Sinus Rhythm	5	5		P121413S

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
21:47	17 (0)	97 (0)		0	166 (0)	99 (1)	Alert (0)	36.4 (0)	1
21:40	16 (0)	98 (0)		0	170 (0)	91 (1)	Acute Confusion (3)	36.4 (0)	4

HISTORY

AMPLE

Allergies	None
Medication	SEE ECS
Last Eaten	>4 Hours Ago
Events Prior	ONGOING DAILY CHEST PAIN 3/7. ?PREVIOUS CARDIAC HISTORY

Social History

Lives alone	Yes	Patient Occupation	PAINTER

Patients General Appearance	Normal
Patient Mobility	Fully Mobile
Patient Communication	No Help Required
Patient Clinical Risk Factors	Alcohol, Smoker
Patient Enviromental Risk Factors	None Identified

CLOSE RECORD

Treatment On Scene	Non-Emergency

Conveyance

Transport To Hospital	Normal driving	Pre-Alert	No

INCIDENT LOG

Time Call Received	20:58	Allocated	21:09	Mobile	21:14
First Resource On Scene		Crew On Scene		Crew Left Scene	
Crew At Hosp		Receiving Hospital		Clear Time	

Crew ID	Crew Grade	Driver
E9882989	Ambulance Technician	YES
E9883169	Paramedic	NO
P121413S	Student Paramedic (BSc Placement)	NO

OBS 7. S|C

Crosshouse EMERGENCY DEPARTMENT

NHS Ayrshire & Arran

A/E No: XH-23-047519-1
Date & Time: 12 Oct 2023 22:21

CHI No: 1406650854

Stephen GALLOWAY

Duty Consultant: DR JAYNE MCLAREN

Date of Birth: 14 Jun 1965
Age: 58 Years
Sex: M

GP:
V Bothwell
Frew Terrace Surgery
9 Frew Terrace
Irvine
KA12 9DY
01294 272326

Marital Status: Single

Address:
28 REDBURN PLACE
IRVINE
AYRSHIRE

KA12 9BH

Next of Kin:
Hugh Galloway
Brother

Religion: None
Ethnicity: White Scottish

Attendances
Last 12mths: 2
Total: 21

Phone Numbers:
Home: 07468337186
Mobile:

Special Case:

Employer/School:
Not at School

Accompanied by: Unaccompanied

Triage Time: 22:40 **Triage Nurse:** Owen Charles **Triage Group:** Yellow

Resp Rate	O2 Sat%	PFR
16	98%	

Pulse	BP	E	M	V
88	160|96	4	6	5

Allergies: No Known Allergy

BMstix	NEWS	Temp	Weight
		36.4	

Visual Acuity
R:
L:

Pain Score Triage: 3

Triage details:
biba- ongoing central chest pain for few days. self d/c 2/7 ago. intoxicated
Treatment
NONE Bloods ECG
Special Needs
NONE
Clinical Frailty Score:
Re-assess in 15 30 60 minutes

I give consent for details of my injury to be given to the Police.
Signed:.....

Against Medical advice I decline the treatment offered. I know this may affect my recovery.
Signed: ..... Witness: ... . Witness: .....

Disch · A+E clinic · Paed Tr. · # Eye · ENT · Facial
Ward OP · Ward IP... Zone 1 Bed 5

1406650854

Stephen Galloway CHI: 1406650854 A/E No: XH-23-047519-1

Drug	Dose	Route	Time/Freq	Signature	Given By	Date	Time
PABLINEX 2	(1+1+1)	IV				15/10/23	
DIAZEPAM	5MAWS	PO			(AS PER CITALC		

Kardex started? ☐ Further dru

MEDICATION ON HEPMA

do not print further ED Cards

PVC	Size/Colour	Location	e/Colour	Location	Initials
1					

	Device	Flow R l/min		Target SpO2	Prescribed by	Started by	Stopped by
Oxygen							
Changed to							

Clinician Name: KBurden ED SG **Date:** __/__/____

Grade: **Time:** _____

58

Self d/c 2/7 after result
with Cleft/epileptic pain
Represented feeling generally unwell
N&V. Poor oral intake
Further CP - but now resolved
Had not drunk for 2/7, felt
shaking so had 6x whiskeys
this am.
Feels 'unwell' but no further CP.
Mind & oral intake 48hrs.
No fever. (N) BPs / PU.

O/E
GCS 15
Clerk clear
NSSNM
ASNT.
No news.

ECG NSR

I/ ETON XS
Domperidone

P/ Pabrinex
5MAWS
IVF + K+
Admit medics

Patient Name	CHI	Date Of Birth	Age
Stephen Galloway	1406650854	14/06/1965	58

Repeat Medication

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Continue	Withhold	Stop	Comments

Compliance Device	Name and telephone number for community pharmacy

Completed by	Designation	Grade	Date	Time	Contact Number
J. Kupcan	Pharmacist		13/10/22		
Reviewed by	**Designation**	**Grade**	**Date**	**Time**	**Contact Number**

Patient Name	CHI	Date Of Birth	Age
Stephen Galloway	1406650854	14/06/1965	58

Source of Information

Patient	✓	Relative / Carer		Patient's Own Drugs		GP Letter		GP Practice	
Care home / MAR Chart		Previous Discharge Letter		Repeat Prescription Slip		Community Pharmacy		Other (Please State)	

Allergy Description	Date Recorded	Comments

Acute Medication (including those greater than 30 days)

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Continue	Withhold	Stop	Comments

Repeat Medication

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Continue	Withhold	Stop	Comments
	Tadalafil	5 mg Tablets	ONE TAB DAILY		20-Sep-2018	04-Sep-2023		~~—~~			
	Salbutamol	100 micrograms/puff Cfc-free inhaler	ONE TO TWO PUFFS TO BE INHALED AS REQUIRED FOR BREATHLESSNESS		25-Jan-2019	04-Sep-2023		✓			
	Co-Codamol 15/500	Tablets	ONE OR TWO TO BE TAKEN		03-Oct-2019	04-Sep-2023		✓			

Patient Name	CHI	Date Of Birth	Age
Stephen Galloway	1406650854	14/06/1965	58

Repeat Medication

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Continue	Withhold	Stop	Comments
			FOUR TIMES A DAY WHEN REQUIRED								
✓	Amitriptyline Hydrochloride	25 mg Tablets	ONE INCREASING TO 2 AT NIGHT IF REQD/TOLERATED		03-Oct-2019	04-Sep-2023			✓		↓Na
✓	Spiriva Respimat	2.5 micrograms/dose Inhalation Solution Cartridge With Device	TWO PUFFS TO BE INHALED EACH DAY		07-Feb-2020	04-Sep-2023		✓			
✓	Lansoprazole	30 mg Capsules (Gastro-Resistant)	ONE TO BE TAKEN EACH DAY		21-Feb-2014	04-Sep-2023			✓		↓Na
✓	Thiamine Hydrochloride	100 mg Tablets	ONE TO BE TAKEN THREE TIMES A DAY		17-Aug-2018	04-Sep-2023		✓			

Crosshouse Emergency Department

Name: Stephen Galloway **CHI No: 1406650854**

ED 4AT Delirium Assessment: Complete / update for all Patients over 65, anyone of any age, with a cognitive impairment/previous delirium, current hip fracture, acute illness or SQID positive (is your patient more confused or drowsy than normal?)				N/A? ✓
ALERTNESS: This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient, if asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating. Circle relevant number below	Date			
	Time			
Normal (fully alert, but not agitated, throughout assessment)		0	0	0
Mild sleepiness for <10 seconds after waking, then normal		0	0	0
Clearly abnormal		4	4	4
AMT4: Age, date of birth, place (name of the hospital or building), current year				
No Mistakes		0	0	0
One Mistake		1	1	1
Two or more mistakes		2	2	2
ATTENTION: Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "What is the month before December?" is permitted.				
Achieves 7 months or more correctly		0	0	0
Starts but scores < 7 months / refuses to start		1	1	1
Untestable (cannot start because unwell, drowsy, inattentive)		2	2	2
ACUTE CHANGE OR FLUCTUATING COURSE: Evidence of significant change or fluctuation in: alertness, cognition, other mental function (e.g. paranoia, hallucinations) over the last 2 weeks and still evident in the last 24 hours.				
No		0	0	0
Yes		4	4	4
	Total			
	Signature			
4AT Score of 4 and above: Possible delirium +/- cognitive impairment (C nplete the TIME bundle below)				
4AT Score of 1-3: Possible cognitive impairment				
4AT Score of 0: Delirium or severe cognitive impairment unlikely (but deli ium still possible if [4AT] incomplete)				
TIME BUNDLE: Complete the TIME bundle if the **4AT Score if 4 and above**.				
	Date			
	Time			
T	Think possible triggers for delirium	Use Codes: Y-Yes N-No NA- Not applicable		
	Is the patient in pain? (start pain chart, review analgesia)			
	Is the patient constipated or at risk of constipation? (Commence bowel chart and aperients).			
	Is the patient in urinary retention? (Palpate bladder/scan)			
	Is the patients' oral intake sufficient to prevent dehydration? (Encou age hourly fluids start FBC)			
	Could any drugs trigger delirium? (Doctor to review medication)			
	Blood sugar, high or low?			
	Is there a history of alcohol intake/drug abuse? (Intoxication or withdrawal, GMAWS/drug misuse)			
I	Investigate			
	Record NEWS			
	Screen for infection (and consider urinalysis)			
	Take bloods and ensure ECG/appropriate imaging			
M	Management: Diagnose causes & initiate treatment			
	Document diagnosis of delirium			
	Document potential causes of delirium			
	Document treatment plan			
E	Engage and Explore			
	If appropriate, explain diagnosis of delirium to patient/family/carers and provide delirium leaflet			
	Engage with patient/family/carers. ("What matters to me"/ "Getting to know me")			
	Does the patient have capacity to consent to care? (In no, complete AWI document)			
	Signature:			

CROSSHOUSE EMERGENCY DEPARTMENT

Name: Stephen Galloway **CHI No:** 1406650854
Address: 28 REDBURN PLACE IRVINE AYRSHIRE KA12 9BH
Arrival Date/Time: 12 Oct 2023 22:21

Nurse Signature on initial assessment: Owen Print Name: OWEN CHARLES

Triage Comments:	biba- ongoing central chest pain for few days. self d/c 2/7 ago. intoxicated
Past Medical History	A/C X5, COPD

DNAR	Y	N/A	AWI	Y	N/A	Insulin	Y	N/A	On Anticoagulant?	Y	NA

Allergies		Medications given by Paramedics	

Nursing Notes: Care taken over by

Date/Time	Name Printed	Signature
13/10/23	Jenna McClure	JMcC
14/10/23 07 40	Margaret Cardon	m cn

Name band in situ			Y	N	Patient prepared for exam & clothes bagged	Y	N
ECG	1st ✓	2nd		Other	Valuables with patient:	Y	N
IV Access			Y	N	*If yes, please specify action taken*		
PVC Size/Colour:	pink				Relative/Carer/Next of kin present:	Y	N
PVC Location:	R hand				Name: Relation:		
Inserted by:	SN				Contact Number:		
Blood samples			Y	N	Language, visual or hearing difficulty:	Y	N/A
Blood gases			Y	N	*If yes, please specify:*		
Blood cultures			Y	N	Interpreter required:	Y	N/A
PCR Test			Y	N	*If yes, please specify:*		
Radiology			Y	N	Package of Care?		

Screening tools Assessment	Date 12/10 Time		Date Time			Date 12/10 Time		Date Time	
SEPSIS SCREEN	Y	N	Y	N	Adult Support & Protection	Y	N	Y	N
FAST Score	Y	N	Y	N	McKillop Tool	Y	N	Y	N
AAMAWS commenced	Y	N	Y	N	Child Protection/Wellbeing	Y	N	Y	N
Big Six (hip fracture	Y	N	Y	N					

Mobility	Bed Rest		Independent	Assistance/walking aid, specify:

If **YES** to any Falls Risk Assessment questions complete the safety intervention section. Repeat if the patient has a fall, is taking risks, has a change in condition/cognition.

Falls risk Assessment	DATE 12/10 TIME		DATE TIME		**Safety interventions**	DATE TIME	DATE TIME
Admitted with a fall?	Y	N	Y	N	Nonslip socks provided?	Y	Y
Recent fall (last 6 months)?	Y	N	Y	N	Behaviour monitoring chart	Y	Y
Cognitive impairment or possible delirium?	Y	N	Y	N	Supervision required in bathroom/commode?	Y	Y
Attempts to walk alone is unsteady/unsafe	Y	N	Y	N	Falls warning sign on whiteboard/symphony	Y	Y
Is patient at high risk of falling?	Y	N	Y	N	Bed in Visible area.....	Y	Y

Nursing Notes Continued – Bundles/Stickers

Crosshouse Emergency Department

Name: Stephen Galloway **CHI No: 1406650854**

Nursing Notes		
Date/Time		Signature
1715	Hot Drink Given	
2000	Received pt. awake on trolley, connected to telemetry NEWS 2 - HR 113. AAMAWS -2, 5mg long diazepam.	
2115	Transferred to hospital bed. Independent to toilet.	
22:30	SANDWICH & COFFEE GIVEN	
2320	Pt moved to corridor in bed. Diazepam 10mg given as per gmaws, known tremor on movement. Evening medication given as prescribed. Appears settled.	JMcCle
14/10 0415	Remained settled overnight	JMcCle
0740	patient Care taken over by day shift; News 1 due to increased heart rate 105bpm, AAMAWS Score remains 1 due to tremor on movement 10mg diazepam given as charted, morning medication given as charted, breakfast taken	mCar
	patient awaiting bed in medical	mCar

Crosshouse Emergency Department

Name: Stephen Galloway **CHI No: 1406650854**

Nursing Notes		
Date/Time		Signature
12/10/23	BIBA - CENTRAL CHEST PAIN +	
2250	INTOXICATED.	
	GCS 15	
	BLOODS ✓	
	ECG ✓	
	NEWS - 0	
	A/W. GO R/V ——— CC.	
13/10/23	- NEWS - 1 HR 94. - AWBK.	
0155	Assisted to bathroom - PV..	S/N. S
0325	IV access obtained for	
	K+ replacement. Assisted to	S/N Sm
	bathroom	
0600	REFERRED TO MEDICS. IV KCL	
	INFUSION ONGOING.	
	TO START 6 MANS CHART WHEN	
	IF STARTS WITHDRAWING ——— CC.	
0645	PULLED CANNULA OUT TO	
	GO TO TOILET.	
	RE-CANNULATED L ACF	
	SIZE PINK. KCL INFUSION	
	RESTARTED	
	CONTINENT OF URINE SOAKS — CC	
1148	Lunch given ———	N
1240	Patient agitated. ? in DTs.	
	Medic placed. Will restart	
	6 MANS ———	N
1300	20mg diazepam given ———	N
1700	Patient updating family on phone	

Crosshouse Emergency Department

Name: Stephen Galloway **CHI No: 1406650854**

ED Care Round Checklist:

Frequency to be prescribed in relation to the patient's greatest need

To be completed by the member of staff delivering care. If unable to use the nurse call bell prescribe care and comfort at one hourly

Date /Time	Name	Designation	Signature	Circle frequency prescribed
				1 2 3 4
				1 2 3 4
				1 2 3 4

Use the following codes; **Y** – Yes **N** – No **NA** – not applicable **NT** – No Thanks

S – Sleeping **O** – Out of department **I** - Independent

	Date	12/10	13/10		13/10	13/10	13/10	
	Time	22:50	05:55	11AM	14:00	21:00	05:50	09:10
	THINK DELIRIUM: Is the patient more confused or drowsy than normal? *(if yes escalate and update 4AT)*	X	N	X	X	N	N	N
	PAIN: ASSESS AND ADDRESS . Is the patient distressed and/or in pain? *If yes inform nurse in charge*	X	N	X	N	N	N	N
S	**SKIN INSPECTION** Pressure areas checked? **R**-red D-discolouration **U**- pressure ulcer **E**-moisture/excoriation **N**-no damage Barrier Cream applied **Y**-Yes **N**-No	NOAD/CWAND	N	X	N	N	N	N
	Cushion/heel protector appropriate: **Y**-Yes **N**- No Type		—		/	N	N	N
K	**Keep moving** Has the patient changed position or walked?		4	✓	4	4	4	4
	Bed: **R**:right side **L**: left side **B**: back **I**: independent		1	(1)	(1)	I	1	1
	Chair: **W/ST**: Assisted to walk/stand **I**: independent		B	B	(1)	I	1	1
	Sliding Sheet used		—		/	NA	—	—
I	**Elimination**: Patient offered the toilet?		1	(1)	(1)	4	4	4
	I independent **A** assistance given **IC** incontinence (urine/faeces) **BO** Bowels open **C** Catheter	N/A	N	PU	1	I	1	1
N	**Food/Fluid and Nutrition** Fasting **F** Nil by mouth **NBM**		N			4		
	Drink taken	✓	4	✓	✓	4	4	4
	Food, snack or supplement taken		N	✓	✓	NT	—	—
	Oral hygiene carried out		—			N	—	—
	Environmental check: is the nurse call bell to hand, area clutter free, belongings within reach	✓	4	✓	✓	4	4	4
	Is the trolley/bed at the lowest level	✓	4	✓	✓	4	4	4
	Information: is there anything I can help you with? Inform patient of return time	✓	4	✓	✓	4	4	4
	Escalation required to nurse in charge?	X	N		N	N	N	N
	Move bed/trolley to visible area if taking risks	X	N		N	N	N	N
	Patient stay > 12 hours? - Consider moving to a bed	X	—		N	N	N	N
	If patient on bed, complete a bedrail risk assessment	X	—			N	N	N
	Initials	OS	SN	OS	JN	SN	SN	SN
	Designation	SN	SN	SN		SN	SN	SN

Crosshouse Emergency Department

Name: Stephen Galloway **CHI No: 1406650854**

Preliminary Pressure Ulcer Risk Assessment (PPURA), update daily:
Mobility: Patient requires assistance to mobilise/change position. Continence: Patient has continence issues which may/has compromise/d skin. Nutrition: Patient appears malnourished and/or unable to eat/drink. Skin: Patient has a pressure ulcer/skin is compromised (medical devices, neurological deficit, medication, co-morbidities)
If YES to any of above, activate care plan below

Date	Time	Mobility		Continence		Nutrition		Skin		Sign
12/10/23	2245	Y	N	Y	N	Y	N	Y	N	
		Y	N	Y	N	Y	N	Y	N	

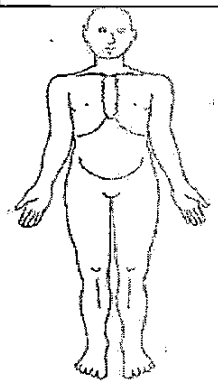
Pressure Prevention Care Plan

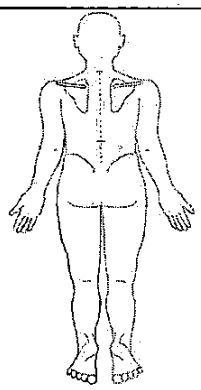
Patient is **at risk** of developing a pressure ulcer? Y ☐ N ☑

Patient **has** a pressure ulcer? Y ☐ N ☑ **(If yes to either, initiate care plan below)**

Date	Initial	Nursing intervention	Discontinued	Date/Time	Sign
		Ensure regular repositioning is carried out and documented on SSKIN bundle			
		The patient should not sit out of bed for longer than 2 hours without being repositioned (for acutely ill patients return to bed for a minimum of 1 hour)			
		Use sliding sheets to prevent shear and friction during movement in bed and record use in care round. Sliding sheets should not be left under the patient.			
		If the patient is incontinent use a PH balanced cleanser to clean and barrier products to protect as per: 'Scottish excoriation and moisture related skin damage tool'.			
		Move patient to bed with foam redistributing mattress			
		Encourage a healthy, well-balanced diet and adequate fluid intake.			
		If the patient has a grade 2 or above pressure ulcer a wound assessment chart is required. Available from AthenA			
		Plan of care discussed and agreed with the patient as appropriate. Evaluate care in the nursing records.			

Date/Time	Location of ulcer	Grade of ulcer	Signature





NHS Ayrshire & Arran

Acute Assessment Proforma

GALLOWAY Stephen
28 REDBURN PLACE, IRVINE
KA12 9BH
DOB: 14/06/1965

Date: 13/10/17 Time: 07:50

Referral source: G.P. Consultant: MANNECH

Presenting Complaint and relevant History

58 → ADMITTED TO ED ACUTELY intoxicated.

HAD DRANK ALOT prior but reattended with 'chest pain'. Central + worse on deep breathing. Associated with some vomiting. NOTHING HELPS except Alcohol.

No HAEMATEMESIS or MELAENA.

PAIN HAD BEEN PRESENT for > 1 week.

Past Medical History

COPD.

- TOX DEPENDENCE.

Systems Enquiry

Family History

Social History

Employment: Driving status:

Lives with: Recent Travel:

Mobility: Functional Capacity:

Family Support: Smoker:

Home Care: Alcohol (units/wk): ~~5~~ unknown How Quantity

Staple Med Rec Here **Medication History and Multidisciplinary Medicines Reconciliation**

Must be started by the admitting Clinician and reviewed by the pharmacist within 24 hours

Please print ECS in the medicines reconciliation format and take medication history from the patient or relative & do medicines reconciliation and staple to this page. If not possible, use table below.

Allergies & Adverse reactions:→

Medicines / Substance	Reaction
NKDA-	

Details of Medicines obtained from

PODs		ECS		Nursing Home Chart		Recent IDL	
Patient		GP Letter		Community Pharmacist			
Relative/Carer		Phone call to GP		Other (please specify)			

Medicine	Dose	Frequency	Continue	Amend	Suspend	Stop	Comments
THIAMINE	100mg	TDS	—				
Co-codamol 15/500							
Not been for							

See ECS insert

Are you satisfied this medication history is complete and accurate? YES ☐ NO ☐

If NO what further action is necessary (Contact GP etc.) ..... Tick when resolved ☐

Doctor/ANP signature ..... Date/Time ..... Beep No .....

Pharmacist Signature J. Kirkpatrick Date/Time 13/10/23 Beep No .....

General Examination and Cognitive Assessment:

BP - Lying : Standing (1 min) : (3 min) : Pulse:

Temp: RR: SpO_2: % on air or FiO_2: **NEWS**:

4AT score: Is AWI needed? Yes/No . Clinical Frailty Score:

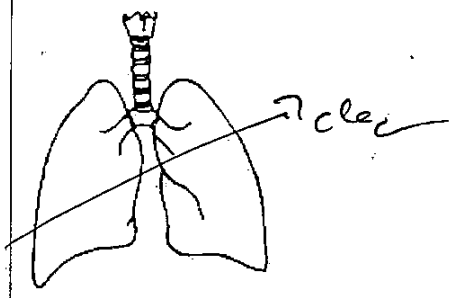
Other findings (Skin, Joints, Calves, etc.): Left sided chest wall tenderness.
Calves soft non tender

Cardiovascular Examination

Pulses: Heart rate/rhythm: regular Heart sounds/Murmurs: Ejection

/P: Pedal oedema: Heaves / Thrills:

Respiratory Examination



PEFR:

Abdominal Examination

Bowel sounds:

PR exam:

Neurological Examination: GCS: 15 /15 (E___/4, M___/6, V___/5)

Gait: Cranial Nerves:

Meningism:

Cerebellar signs: Fundoscopy:

	RUL	LUL	RLL	LLL
Pronator drift			-	-
Tone				
Power				
Reflexes				
Sensation				
Co-ordination				
Plantar reflexes				

Investigations:

Relevant Bloods: FBC (N).

Trop - 9 - 10

K^+ = 2.9

Na = 127.

CXR: A/W

ECG: NSR.

ABGs:

Urinalysis: Leucocytes Nitrites Protein Blood Glucose Ketones

Differential Diagnoses / Problem list & Treatment Plan

IMP -> Non-cardiac chest pain / Epigastric pain.

-> PAIN on deep breathing with chest wall tenderness
L> likely MSK.

-> Epigastric tenderness -> Gastritis vs pancreatitis.

PLAN (1) PABA x2 + Supplemental O2 + IV PPI.

(2) Gen. ☐

(3) Had K^+ replacement in ED.

(4) AM U+E Amylase.

if All -ve likely (H) Low

Medicine Reconciliation completed	☐	Is there an existing anticipatory care plan/KIS? Yes/No	
VTE Prophylaxis assessed & prescribed	☐	Treatment Escalation Plan (TEP) considered/filled	☐
Antibiotics as per microbiology policy	☐	DNACPR considered/documented ☐ Not Applicable	☐

Name & Grade (ID stamp): M

Signature:

Page no.: 3 5 17

Michael Deighan
Internal Medicine Trainee
7751000, Page ....

Location:

Time:

Further review as needed: Date: **Time:** **Location:** **Signature:**

Venous thrombo-embolism (VTE) prophylaxis risk assessment tool

Do Not Use in Acute Stroke

Risks for thromboembolism (tick if apply)

- ☐ Age >60 years
- ☐ Active cancer or cancer treatment
- ☐ Any significant medical illness
- ☐ Critical care admission e.g. HDU/ITU
- ☐ Dehydration
- ☐ Known thrombophilia
- ☐ Obesity (BMI > 30)
- ☐ Personal history or first degree relative with a history of VTE
- ☐ Pregnancy or < 6 weeks post-partum
- ☐ Significantly reduced mobility for 3 days or more
- ☐ Use of hormone replacement therapy
- ☐ Use of oestrogen-containing contraceptive therapy

1 or more Risk Factors

No Risk Factors ☐

No prophylaxis required
Review decision 3x weekly

Contraindications to Dalteparin (tick if apply)

- ☐ **Lumbar Puncture**/Epidural/Spinal Anaesthesia in previous 4 hours *or expected within next 12 hours*
- ☐ Any other procedure with high bleeding risk expected during this admission (including neurosurgery, spinal or eye surgery)
- ☐ Active bleeding
- ☐ Acute stroke
- ☐ Acute gastro-duodenal ulcer
- ☐ Acquired bleeding disorders e.g. acute liver disease
- ☐ Thrombocytopaenia (Platelets <75x10^9/L)
- ☐ Previous Heparin Induced Thrombocytopaenia (HIT)
- ☐ Uncontrolled hypertension >230/120 mmHg
- ☐ Concurrent use of any other anticoagulants(e.g. Warfarin)
- ☐ Any other concern (document in case notes)
- ☐ Untreated inherited bleeding disorders

Any Contraindications ☐

Do not prescribe LMWH
Consider Anti Embolic stockings.
Review decision 3x weekly

No Contraindications ☐

Please prescribe Dalteparin 5000 units subcutaneously once daily ☐

FBC (platelets) to be checked on day 0 and day 1. **Review VTE prophylaxis 3 x weekly**

NB. Reduction of prophylactic dose NOT required for patients with renal impairment (eGFR <30 ml/min)

Discussion with patient regarding risk of VTE & risks/benefits of LMWH ☐

☐ **Suspected DVT or Pulmonary Embolism** should receive treatment dose Dalteparin, until excluded.

NB. Treatment dose LMWH should be reduced by 20% if eGFR <30 ml/min – see ADTC 75

GALLOWAY Stephen
28 REDBURN PLACE, IRVINE
KA12 9BH
DOB: 14/06/1965

ABL90 CROSSHOUSE AVE GREEN I393-092R0 11:25 13/10/2023
PATIENT REPORT Syringe - S 65uL Sample # 14292

Identifications		
Patient ID	1406650854	
Patient last name	Galloway	
Patient first name	Stephen	
Sample type	Venous	
Temperature	37	
$FO_2(I)$	21.0 %	

Blood gas values				
pH		7.418		[7.350 - 7.450]
pCO_2		4.79	kPa	[4.27 - 6.40]
↓ pO_2		7.32	kPa	[11.1 - 14.4]
cH^+c		38.2	nmol/L	[-]
Oximetry values				
ctHb		146	g/L	[115 - 178]
↓ sO_2		87.5	%	[94.0 - 98.0]
↓ FO_2Hb		85.4	%	[94.0 - 98.0]
FCOHb		2.1	%	[0.0 - 3.0]
↑ FHHb		12.2	%	[0.0 - 2.9]
FMetHb		0.3	%	[0.0 - 1.5]
Electrolyte values				
cK^+		4.0	mmol/L	[3.5 - 5.1]
cNa^+		140	mmol/L	[136 - 145]
cCa^{2+}		1.21	mmol/L	[1.15 - 1.33]
cCl^-		106	mmol/L	[-]
Metabolite values				
cGlu		4.9	mmol/L	[4.1 - 5.6]
cLac		1.6	mmol/L	[0.2 - 1.8]
Hctc		44.8	%	[36.0 - 53.0]
Oxygen status				
ctO_2c		7.8	mmol/L	
$p50_c$		3.63	kPa	
Acid-base status				
$cBase(Ecf)_c$		-1.3	mmol/L	
$cHCO_3^-(P,st)_c$		23.4	mmol/L	

Notes
↑ Value(s) above reference range
↓ Value(s) below reference range
c Calculated value(s)

Solution pack lot: PE-30
Printed 11:25:42 13/10/2023
Sensor cassette run #: 2253-252

Pneumonia — Pulmo… — …sis

CURB65 Score

C	Confusion (4 point AMT ≤3)	1
U	Urea >7 mmol/L	1
R	Respiratory Rate >30/min	1
B	Systolic BP <90 mmHg	1
65	Age greater than 65	1

Score 0 - 1 = Mild = PO Abx
Score 2 = Moderate = IV Abx
Score ≥ 3 = Severe = IV Abx

Always refer to local antibiotic policy

Use clinical judgement (e.g. bilateral pneumonia, degree of hypoxia).

Two-…

Clini…
Alte…
He…
In…
I…

…sound

…nt

Upper GI Bleed

Glasgow Blatchford Score

Criterion	Male	Female	Sc…	Points
Hb (g/dL)	120-130	100-120		1/year
	100-120	-		10
	<100	<100		30
Urea (mmol/L)	6.5 - 8			10
	8 - 10			10
	10 - 25			20
	>25			30
Systolic BP	100 - 109			20
	90 - 99			20
	< 90			60
Pulse ≥ 100	Preser…			20
Melaena	Prese…			
Syncope	Pres…			
Liver	Pre…			
CCF	Pr…			

Score 0 – 1; consid…
Score >6 = 50% lik…

…-day all-cause mortality

	Risk
0-1.6%	Very low
1.7-3.5%	Low
…/105 3.2-7.1%	Moderate
…6-125 4.0-11.4%	High
…>125 10-24.5%	Very high

TIA Assess…

…lar AF anticoagulation

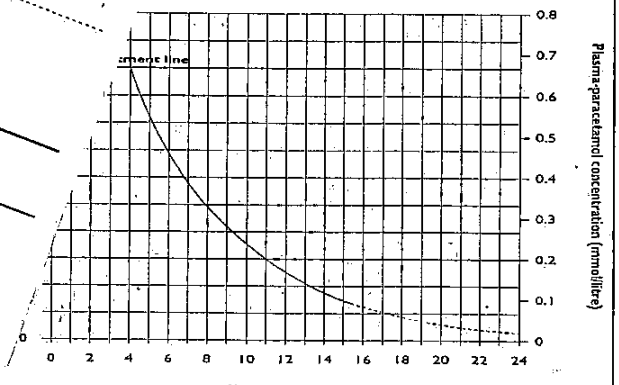
$ABCD_2$ Sc…

…Vasc

Age > 60	…re 1
BP >140 / …	…ion 1
Speech dis…	…74 1
Unilateral …	… 2
Duration …	…s 1
Diabete…	…us TIA or stroke 2
Score	…ular disease 1
Scor…	…ale 1

…1, for Warfarin
…onsider LMWH & novel oral anti-coagulants.

…rotocol for Paracetamol OD treatment



Patients whose plasma-paracetamol concentrations are on or above the treatment line should be treated with acetylcysteine by intravenous infusion.
The prognostic accuracy after 15 hours is uncertain, but a plasma-paracetamol concentration on or above the treatment line should be regarded as carrying a serious risk of liver damage.

Graph reproduced courtesy of Medicines and Healthcare products Regulatory Agency

Anion Gap

$= (Na^+ + K^+) - (Cl^- - HCO_3^-)$

Used to assess the contribution of unmeasured anions to acidosis. Normal range 10-20 mmol/L.

patient frail, sick and at risk of deterioration/dying? Yes ☐ No ☐

yes, please discuss treatment escalation plan with patient and/or elative, and complete Treatment Escalation Plan (TEP)

EP completed? Yes ☐ No ☐

)NACPR considered / completed? Yes ☐ No ☐ N/A ☐

Write or attach label

CHI No .....

Surname: GALLOWAY

Forename: S ..... Sex: .....

DOB: 14/6/65.

Consultant Review: Date: 13.10.13. Time: 0:39. Location: ED OBS 7.

1) CP (FALL) ⑥ SOBOE ? MSK. - ECHO X3.

2) LOW K+

CMAMS 0. - NEWS 0-1.

P - SMOKE.

CXR.

(K+) - TROPONIN.

ECG: NSR. CXR: NAD. AMYLASE 63. HbA1c 9 → 10

BLOODS: K+ 2.9 Na+ N.T ↑AST ALT FBC (N).

(P) CXR

BLOODS NOW. If K+ ≥ 3 + CXR OK → (H).

SATND OF. P

SIMPLE ANAL ☑

PH

Dr Philip Hodkinson
Consultant Physician in
Respiratory Medicine
GMC 4532387 • Page 3817

Specialty Allocation:	Discharge anticipated today: Yes ☐ No ☐
Med. Rec. ☐ VTE prophylaxis ☐ AWI ☐	EDD: or <24hr 24-72 hrs >72 hrs
Consultant Signature:	
Name (ID Stamp):	

Write or attach label
CHI No 1406505884
Surname: Galloway
Forename: Stephen Sex: .....
DOB: .....

Continuation

13/01/23 Pharmacy
1224

Na 127 – taking amitriptyline 50mg daily & Lansoprazole 30mg daily regularly at home. Have suspended whilst hyponatraemic. Rlu & restart as appropriate

J. Kpanick
#3574

16/10/23 CXR WR

58 → · History noted
* fall → self discharge
* chest pain → Jaundice ? hx.
↳ biliary M.S.
* Alcohol issues. => on GEMS

obj status
· No PT,
· E.D okay

CNS not focal.

Write or attach label

CHI No .....

Surname: .....

Forename: ..... Sex: .....

DOB: .....

Continuation

CKD nil acute.

Blood → awaited (last was 14/10/25)

Plans
- Cont IVI.
- monitor blood
- Home likely tomorrow
- Assess

Write or attach label

CHI No .....

Surname: .....

Forename: ..... Sex: .....

DOB: .....

Continuation

NHS Ayrshire & Arran

CAU Referral Information

Date: 13/12/20 Time call taken: 01 59

Name call handler: Laura

CHI 140665085 Age 55

Surname Galloway

Forename. Steven

GP name/practice

Referral source:

GP- Letter: with patient/ mailbox **From- Nursing Home/ Home**

Apply Front Door Covid– 19 risk assessment RED/GREEN

ED- Acute Med/ ED pathway **ED Time of arrival:** 23.18 **SPECIALTY:**

Other- **SHEILDING Y/ N**

Ambulance- Y / N

Reason for referral: DTs stopped 5 days ago, malena

Observations - RR 17 SpO2 100 Sup' O2 Temp HR 100 BP 127/80 AVPU A

CLINICAL ALERT PRESENT	RED FLAG	FRAILTY

RECEIVING NURSE: _____ TIME OF ARRIVAL: _____

BACKGROUND

RELEVANT PAST MEDICAL HISTORY	ALLERGIES:	YES	NO	UNKNOWN
	ANTICOAGULANT:	YES	NO	UNKNOWN
	INSULIN:	YES	NO	UNKNOWN

NEXT OF KIN DETAILS:

NAME: CONTACT NO:

RELATIONSHIP:

POA: NO AWI: NO

YES- details: YES

ASSESSMENT

Condition at first presentation:

NEWS SCORE:			ANY MEDICATIONS GIVEN BY PARAMEDICS/ OWN MEDICATION LAST TAKEN		
GCS:					
MEDICS INFORMED:	YES	NO	O2 THERAPY	YES	NO
NAME BAND INSITU:	YES	NO	AMOUNT:		
OWN MEDICATIONS:	YES	NO	PVC INSERTED PRE-HOSPITAL	YES	NO
ECG:	YES	NO	MCKILLOP SCORE:		
CXR:	YES	NO	STROKE REFERRAL:		
Blood cultures:	YES	NO	COGNITIVE IMPAIRMENT:	YES	NO
ABGs:	YES	NO	4AT:		
IV fluids:	YES	NO			
IV medication:	YES	NO	Troponin due:		

SEPSIS SIX: **Immediate review required Y/N** Scottish Structured Response for ALL patients with NEWS ≥ 5 single Red score or clinical concern	**PVC** – think **DRIFT** (Diagnostics, Resuscitation, IV medication, Fluids, Transfusion) PVC: YES NO (complete bundle) Catheter: YES NO (complete bundle)
Does patient have conditions that require medications pending medical review? Y/N (Myasthenia Gravis; Parkinson's disease; Insulin dependent diabetic: Seizures: Steroid dependency/ Addisons) Review clinical alert printouts if present	**Patient suitable for red dot chairs Y/N** Name of assessor .....Time .....
MOBILITY STATUS:	PACKAGE OF CARE/HOME CIRCUMSTANCES:

	ON ARRIVAL	TIME:	TIME:	TIME:	TIME:	TIME:	TIME:	TIME:	TIME:	TIME:
Orientated										
Family Aware										
Skin Inspection (Waterlow)										
Pain Assessed										
Possessions to hand										
Food/ Fluid Offered										

	Required	**Performed**		**Required**	**Performed**
U&Es			**ABG**		
FBC			**LFTs**		
Glucose			**TnT**		
Coag			**ECG**		
Lactate			**CXR**		
CRP			**Urine**		
VBG			**Other tests**		
Blood Cultures					

Brief clinical summary of review or events in IAA:

Name assessor ..... Role ..... Time review .....

0851

CROSSHOUSE HOSPITAL
EMERGENCY DEPARTMENT

NHS Ayrshire & Arran

A/E No: **XH-20-055125-1**

CHI No: **1406650854**

Date: **12 Dec 2020** Time: **23:18**

Consultant: **Euan McKenzie**

GALLOWAY

Stephen

GP
Dr. V BOTHWELL
FREW TERRACE SURGERY
9 FREW TERRACE
IRVINE
AYRSHIRE
KA12 9DY

Incident Date: **12 Dec 2020**
Incident Time: **23:18**

Martial Status: **Single**

Date of Birth: **14 Jun 1965** Age: **55 Years**

Sex: **M**

Address:
28 REDBURN PLACE
IRVINE
AYRSHIRE

KA12 9BH

Ethnicity White Scottish

Religion None

Next of Kin:
Given

Attendances in last 12mths
2

Total Attendances Count
17

Phone Numbers:
Home: 07468337186

Employer/School
Not at School

Accompanied By:
Unaccompanied

Special case

Triage Time 23:20 **Triage Nurse** Samuel Brown **Triage Group** Yellow

Resp Rate	02 Sat%	PFR
17	100	

Pulse	BP	E	M	V
111	127 /80	4	6	5

Allergies: **No Known Allergy**

BMstix	Alcohol	Temp	Weight
8.4		37.6	

Visual Acuity
R 3 L 3

Pain Score (Triage) 10

Pain Score (Discharge)

Triage details
BIBA; Alcohol withdrawal. Hallucinating since Thursday. Last drink Tuesday.

Treatment
NONE

Clinical Frailty Score:

Special Needs
NONE

Re-assess in 15 30 60 minutes

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed.....Witness.....Witness.....

I give consent for details of my injury to be given to the Police.

Signed.....

*1406650854

Disch A+E clinic Paed Tr. # eye ENT Max Facial Ward OP Ward IP

A/E No. XH-20-055125-1

Drug	Dose	route	time/frequency	signature	quantity/given by
MORPHINE	SMG	IV	q15o		MD.
PARKINEX x I+II	2 PMS	IV	01:45	2	
DIAZEPAM <1 pm	AM			2	
PARKINEX I+II	2PMS.	IV	0945		

PVC1	Size/Colour	Location	Initials	PVC2	Size/Colour	Location	Initials

	Device	Flow Rate l/min	%O2 for Venturi	Target SpO2	Prescribed by	Started by	Stopped by
Oxygen							
Changed to							

DOCTOR / ENP: DINGLE ST6 Time: 13/12/~~202~~ 20?

III Refusal — Hallucination

~~Doctor~~ Psych

BIBA

ANXIETY

DEPRESSION

UPC from AT

Daughter (17) worried

DU/MKDA

TUMOUR

Pancreatic

Bridge Drinker 5-12 DAYS PRIMARY

Tuesday — 5/7 ago

Stopped Alcohol

PMH) Alcohol Panc

COPD

— Rolling — Tremor

GI Bleed

MI

Insomnia Sleeping Aplasia 2/7 ago Drinking

Loc Seizure

Abd. pain

SW

2/7 Hallucinating — saw people in

Lives Alone Likes

Daughter (17)

Talking to self in Lat

Link

Alcohol

2 Late Presenters

Proc.

0/6 Tremor ++

GCS 15

ALT

GN II — XII ✓

Limbs + h. q Tone

Tremor

Sens + Pain ✓/✓

Abd. ✓ Tender

Abd.

XH-20-055125-1

Write or attach label

HCR Number:

CHI Number: 1406650854

Surname: Galloway **Sex:** Male

Forename: Stephen

Address: 28 REDBURN PLACE, IRVINE
AYRSHIRE KA12 9BH

Date of Birth: 14 Jun 1965

MEDICAL CONTINUATION SHEET

DATE	
	PINCH fib cut. PCG-MSK
13/12/20	96 VBG ✓
	INJ. RV SCREEN
0155	(L) Chest well tenderness
	Head + Neck - No signs of injury
	From
	(R) Shoulder - From bed fell
	No bony tenderness
	Spine/hip/leg - (N)
	Issues
	ALCOHOL WITHDRAWAL
	Upper GI bleed
	R/o Pancreatitis
	Falls
	R/o Rib # (L)
	(P) Analgesia + PARACETAMOL
	Mobilise
	CXR
	Bloods inc X/Match 2

Forename: Stephen **Surname:** Galloway

XH-20-055125-1

Date : 12 Dec 2020

DATE		
	CXR — Rt sided CL Pneumothorax — chronic No obvs Rib #	
	CRP 18 WCC/Nat U+E — N Amylase 67	
	Pt is settled + asymp ~~B. Abnt for AD AD Analg~~ Sick Certificate	

XH-20-055125-1

CHI Number: 1406650854

NHS Ayrshire & Arran

Accident & Emergency Nursing Documentation Form

GALLOWAY Stephen

28 REDBURN PLACE

IRVINE

KA12 9BH

DOB: 14/06/1965

PRF: ☐

NHS24 doc: ☐

Date: 12 Dec 2020

Time: 23:18

Additional information for admission complaint:

BIBA; Alcohol withdrawal. Hallucinating since Thursday. Last drink Tuesday.

Receiving Nurse(s): Sam Brown / _____ / _____

Care taken over by: Myerscough / _____ / _____

BACKGROUND

Relevant PMH relating to presenting complaint:

Alcohol dependent

Allergies: Yes (No) Unknown

Anticoagulant: Yes (No) Unknown

Insulin: Yes (No) Unknown

Next of Kin details (if different from A&E Card):

Name:

Relationship: Contact No:

ASSESSMENT

NEWS/PAWS score:

GCS: 15

Name band in situ: (Yes) No

Own medications: Yes (No)

Cognitive impairment: Yes (No) 4AT

Any medications given by paramedics?

O2 therapy Yes (No) Amount:

PVC inserted pre-hospital Yes (No)

ECG	Yes	No
X-ray	Yes	No
CT	Yes	No

McKillop Tool Sepsis Six Big Six

Delirium Bundle

IV	Bloods	Cultures	Gases	Trop	Waterlow
PVC	Yes No	Size/Colour	Location		

Mobility status: Independent

Package of Care Yes (No)

Ongoing Assessment

Y (yes) N(no) (NA) Not Applicable (I) Independent (R) Refused (S)Sleeping

	On Arrival	Time	Time	Time	Time	Time	Time	Time
Area								
Clothing Bag								
Skin inspected								
Pain assessed								
Possessions to hand								
Fluid/Food offered	N/A							

	Nursing Notes
23:30	BIBA: Alcohol withdrawal, hallucinating.
12/12/2020	NEWS 2. - Tacy 1116pm
	GCS 15, PEARL, BM 8.3 — Samuel Brown Staff Nurse Emergency Department
	Await ED rev.
13-12-2020/ 0105	Repeat obs- NEWS 0
0145.	Pabrinex commenced Not currently scoring on GMMUS.
0730	pt now scoring on GMMUS, continue to monitor. Await bed CMO.
0745.	Toxicovery DT. Accepted breakfast. GCS 14/15 due to ~~sleep~~ drowsiness —

COVID-19 NHS Ayrshire & Arran

Patients CHI: Stephen Galloway

Patients name: 1406650854

MEDIUM RISK HIGH RISK

Date swabbed: (SIGN) 12/12/20.

Decision NOT TO SWAB: (SIGN)

Result date:

Positive ☐ Negative ☐

Is there a person shielding/ high risk at the address you are being discharged home too? ☐

Start date of isolation:

End date of isolation:

Ward Admitted To	

NC20-00179

Patient Information		Date:	12/12/2020
STEPHEN GALLOWAY		Incident Number:	CR007026711
Age/Gender:	55y Old Male		
Address:	28 REDBURN PLACE IRVINE ,	Incident Type:	EMG
DOB:	14/06/1965	Incident Location:	O/S DOCTOR ON CALL AREA AT IRVINE ROYAL ACADEMY KILWINNING ROAD IRVINE, KA12 8SJ
CHI:	1406650854		
Ethnicity:			

Scottish Ambulance Service

Adastra 60210.

Presenting Complaint

WITHDRAWELS

Additional Comments

999 call 55yom pt has left sided rib pain worsening on movement. He states he went to gp on call as he was having headaches and halloucinating. Pt is alcohol dependent and has not had a drink since tuesday. Pt is tachy however appears to have full capacity. Gp on call did not see him, he was told to call 111 and left outside to wait for an ambulance. Pt hypertnsive he is known for this and has not taken his medication. All other obs within normal parameters. Transferred to a&e for further obs

PATIENT ASSESSMENT

ACVPU	Alert	<C>	No	
A	Clear			
B	Breathing Adequately: Yes	Respiratory Rate: 17	SPO2: 97	Oxygen Given: No

C	Pulse Rate	BP	Cap Refill	ECG Rhythm
	112	182/114	<=2 Secs	
	Rhythm	Arm	Central/Peripheral	ECG
	Reg	Left	Peripheral	

D	GCS	Eyes	Voice	Motor	PEARL
	15	Spontaneously (4)	Orientated (5)	Obeys Commands (6)	Yes

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
22:53	114	17	182/114	96	<=2s	15	Alert								E9888014
22:50	112	17	182/114	97	<=2 Secs	15	Alert		36.4	8.4					E9888014

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
22:53	17 (0)	96 (0)		0	182 (0)	114 (2)	Alert (0)		2
22:50	17 (0)	97 (0)		0	182 (0)	112 (2)	Alert (0)	36.4 (0)	2

HISTORY

AMPLE

Allergies	Unknown
Medication	COCODOMOL
Last Eaten	Unknown

Social History

Lives alone	No	Living With	DAUGHTER	Patient Occupation	Does Not Work
Patients General Appearance	Normal				
Patient Mobility	Fully Mobile				

Patient Communication	No Help Required
Patient Clinical Risk Factors	Smoker
Patient Enviromental Risk Factors	None Identified

CLOSE RECORD

Treatment On Scene	Non Emergency

Conveyance

Transport To Hospital	Normal driving	Pre Alert	No

INCIDENT LOG

Time Call Received	21:57	Allocated	22:16	Mobile	22:17
First Resource On Scene		Crew On Scene	22:43	Crew Left Scene	22:51
Crew At Hosp	23:04	Receiving Hospital	CROSSHOUSE HOSPITAL	Clear Time	

Crew ID	Crew Grade	Driver
E9888689	Paramedic	YES
E9888014	Ambulance Technician	NO

NHS Ayrshire & Arran

Acute Medicine Assessment Proforma

1406650854
GALLOWAY Stephen
28 REDBURN PLACE, IRVINE
KA12 9BH
DOB: 14/06/1965
XH-20-055125-1

Date: 13/12/20	Time: 04:05
Referral source: ED	Receiving Consultant: CARROLL

Presenting Complaint

55 M Hallucinations

- Normally drinks 2L Captain Morgans/day
- Completely stopped 5/7 ago
- Insomnia, sweating, tremor
- Melaena + dark urine — Hb 126

3° person persecutory auditory hallucinations for 2/7
— 'going to slit his throat'

Denies visual hallucinations with me but written in ED hx

Denies previous episodes of hallucination

Past Medical History

Alcohol XS
COPD
GI bleed
MI
Anxiety
Depression

STA5225PS

ACUTE MEDICINE

Multidisciplinary Medicines Reconciliation

Must be started by admitting Clinician within 24 hours

Source of information (use at least two sources) (Tick)

Patient	☐	Emergency Care Summary	☐
Relative / Carer	☐	Nursing Home Chart	☐
Patient's Own Drugs	☐	Previous Discharge Letter	☐
GP Referral Letter	☐	Repeat Prescription	☐
GP Practice	☐	Other (please specify)	☐

Admission Medicines			Action Note: Unless otherwise indicated below, medicines should be continued on prescription sheet				
Name, Form, Route (specify if not oral)	Dose	Frequency e.g. 3X	Suspend	Amend	Stop	Comments (if medicine suspended, amended stopped or inaccurate)	Pharm initials if change

OTC / Herbal / Homeopathic / Illicit substances	Further information e.g. compliance aid, recent discontinued medicines

Adverse Reactions / Allergies Non known ☐ or

Medicines / Substance	Reaction

Are you satisfied this medication history is complete and accurate? YES ☐ NO ☐

If NO what further action is necessary (Contact GP etc) ..... Tick when resolved ☐

Pharmacist review signature ..... Date/Time ..... Beep No .....
(Initial changes / additions above)

Patient Name	CHI	Date of Birth	Age
Stephen Galloway	1406650854	14-Jun-1965	55

Last Emergency Care Summary received 23-Nov-2020

Details obtained from:

PODs		Relative		GP phone call		Community Pharmacist	
Patient		GP Letter		ECS with consent		Other	
Other Details							

Acute Medication (including those greater than 30 days)

Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Continue	Withhold	Stop	Comments

Repeat Medication

Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Continue	Withhold	Stop	Comments
Amitriptyline Hydrochloride	25 mg Tablets	ONE INCREASING TO 2 AT NIGHT IF REQD/ TOLERATED		03-Oct-2019	23-Nov-2020	✓			
Tadalafil	5 mg Tablets	ONE TAB DAILY		20-Sep-2018	23-Nov-2020	✓			
Salbutamol	100 micrograms/ puff Cfc-free inhaler	ONE TO TWO PUFFS TO BE INHALED AS REQUIRED FOR BREATHLESSNESS		25-Jan-2019	23-Nov-2020	✓			
Thiamine Hydrochloride	100 mg Tablets	ONE TO BE TAKEN THREE TIMES A DAY		17-Aug-2018	23-Nov-2020		✓		while pobiotex
Spiriva Respimat	2.5 micrograms/ dose Inhalation Solution Cartridge With Device	TWO PUFFS TO BE INHALED EACH DAY		07-Feb-2020	23-Nov-2020	✓			
Lansoprazole	30 mg Capsules (Gastro-Resistant)	ONE TO BE TAKEN EACH DAY		21-Feb-2014	23-Nov-2020	✓			
Co-Codamol 15/500	Tablets	ONE OR TWO TO BE TAKEN FOUR TIMES A DAY WHEN REQUIRED		03-Oct-2019	28-Sep-2020	✓			

Non-prescription medicines including herbal/homeopathic/over the counter medication

NKOA

Patient Name	CHI	Date of Birth	Age
Stephen Galloway	1406650854	14-Jun-1965	55

Allergy Description	Date Recorded	Comments

How does patient take medication?
☐ Self Medicates ☐ Drug supervised by carer
☐ Compliance device filled by: ☐ Relative ☐ Chemist, specify:

Completed by:	Name:	Signature: Contact No:	Date/Time:
Reviewed by:	Name:	Signature: Contact No:	Date/Time:

Write or attach label

CHI No .....

Surname: .....

Forename: ..... Sex: .....

DOB: .....

Family History

Social History (As relevant)

Works as: Occasional painter

Lives with: daughter

Mobilises using: no assistance

Home Care: None

Family Support: Daughter does most around house.

Recent Travel:

Functional Capacity:
(eg. climb a flight of stairs?)

Alcohol (units/wk):

Smoker: (Yes) / No / Ex

Systematic Enquiry (As relevant)

Minimal hx

Denies vomiting / pain anywhere

Denies seizures, head/bony injuries

Weight loss / Appetite
Cardiovascular
Respiratory
Gastrointestinal
Urinary
Neurological
Musculoskeletal
ENT / Eyes
Skin
Endocrine
Gynaecology
Mental Health

Physical Activity screening:

Does the patient undertake 30 minutes of moderate physical activity 5 days per week?

Yes ☐ No ☐ If no, consider referral to local council physical activity advice program

ACUTE MEDICINE

General Examination

Temp: 37.1 Pulse: 95 RR: 16

SpO_2: 98 % FiO_2: RA (mask/NP)

BP - Lying: 163 / 114

Standing(1min): /

Calves: SNT

Extremely startled on waking. Jerky movements

Delirium and Cognitive Assessment

4AT score _____ Use if over 65 or confused

Nursing staff will do this on admission; transcribe from their admission document.

The 4AT score helps distinguish delirium from cognitive impairment. Delirium is more likely in the acute setting.

Score ≥ 4: delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: unlikely delirium or cognitive impairment

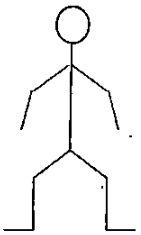
If ≥4 then commence Delirium Pathway

Cardiovascular Examination

HS: I + II + 0

Heaves / Thrills

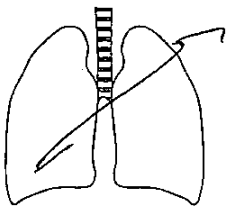
Pulses:



JVP:

Oedema: Nil

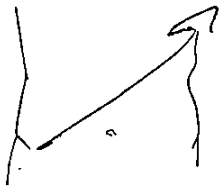
Respiratory Examination



Nil added

Peak flow:

Abdominal Examination



SNT

Bowel sounds:

PR:

General Neurological Examination

GCS: /15 (E___/4, M___/6, V___/5)

Gait? Tremor? Meningism?

Sleeping
AV(O)4

Peripheral and Cranial Nerve Examination

	RUL	LUL	RLL	LLL
Pronator drift			-	-
Tone				
Power				
Reflexes				
Sensation				
Co-ordination				
Plantar reflexes				

Write or attach label

CHI No .....

Surname: .....

Forename: ..... Sex: .....

.....

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

Roche

Measurement report

13.12.2020 01:55
Serial number : 19617
Instrument ID A&E
Operator ID
Crosshouse Hospital

Pat. ID	1406650854			
Last name	galloway			
First name	stephen			
Sample type	Blood			
Blood type	Venous			
Temperature	37.0 °C			
pCO_2	5.47 kPa	[	4.27 -	6.40]
pO_2	6.20 kPa (-)	[	11.07 -	14.40]
pH	7.392	[	7.350 -	7.450]
H	40.5 nmol/L			
BE	0.5 mmol/L			
$cHCO_3$	24.4 mmol/L			
Na	140.9 mmol/L	[	136.0 -	145.0]
K	3.82 mmol/L	[	3.50 -	5.10]
Glu	5.91 mmol/L (+)(1)	[	3.50 -	5.50]
Lac	0.94 mmol/L (-)	[	0.60 -	1.40]
Hct	42.4 %	[	36.0 -	53.0]
SO	82.7 % (-)	[	94.0 -	98.0]
COHb	4.4 % (+)	[	0.0 -	3.0]
HHb	16.4 % (+)	[	0.0 -	2.9]
MetHb	0.6 % #	[	0.0 -	1.5]
Baro	754.0 mmHg			

Note: Ensure reference ranges match sample type
check plausibility
(1) Sensor older than 28 days!

Improving Sepsis S

Systemic Inflammato

Temp >38° or <

White cell count

Heart rate >90

Respiratory rate

Acutely altered
(4-Point AMT ≤

Bedside glucos
(without Diabet

No obvious source? Check
body (e.g. tampon). Consid

*If Severe Sepsis suspecte
Care or ITU referral. Septic*

s or SIRS criteria met.

lines ☐

☐

98% ☐

g ☐

☐

☐

apparent)

der endocarditis or foreign
).

*lical HDU, Medical High
led over accordingly.*

Relevant Investiga

ECG: (N) SR

CXR: NAD
Chronic L

Relevant Bloods:
CRP 18
WCC 14, N(#
Hb 126 (1)
AST 116, ALT 113
U+Es (N)
Amylase 67
Bone (N)

sis:
cocytes:
tes:
ein:
od:
cose:
ones:

ACUTE MEDICINE

Adult Medical Assessment Venous Thrombo-embolism (VTE) Prophylaxis Tool

[ADTC 213/2]

Do Not Use in Acute Stroke

Risks for thromboembolism (tick if apply)

- ❑ Age >60 years
- ❑ Active cancer or cancer treatment
- ❑ Any significant medical illness
  (e.g. cardiac, metabolic, endocrine, or respiratory disease; acute infection; inflammatory condition)
- ❑ Critical care admission e.g. HDU/ITU
- ❑ Dehydration
- ❑ Known thrombophilia
- ❑ Obesity (BMI > 30)
- ❑ Personal history or first degree relative with a history of VTE
- ❑ Pregnancy or < 6 weeks post-partum
- ❑ Significantly reduced mobility for 3 days or more
- ❑ Use of hormone replacement therapy
- ❑ Use of oestrogen-containing contraceptive therapy

→ **No Risk Factors** ❑

→ **No prophylaxis required**
- Review decision 3x weekly

↓

1 or more Risk Factors

↓

Contraindications to Dalteparin (tick if apply)

- ❑ **Lumbar Puncture**/Epidural/Spinal Anaesthesia in previous 4 hours *or expected within next 12 hours*
- ❑ Any other procedure with high bleeding risk expected during this admission (including neurosurgery, spinal or eye surgery)
- ☑ Active bleeding
- ❑ Acute stroke
- ❑ Acute gastro-duodenal ulcer
- ❑ Acquired bleeding disorders e.g. acute liver disease
- ❑ Previous Heparin Induced Thrombocytopaenia (HIT)
- ❑ Thrombocytopaenia (Platelets $<75 \times 10^9$/L)
- ❑ Concurrent use of any other anticoagulants (e.g. Warfarin)
- ❑ Uncontrolled hypertension >230/120 mmHg
- ❑ Untreated inherited bleeding disorders
- ❑ Any other concern (document in case notes)

→ **Any Contraindications** ❑

→ **Do not prescribe LMWH**
- Consider Anti Embolic stockings.
- Review decision 3x weekly

↓

No Contraindications ❑

↓

Please prescribe Dalteparin 5000 units subcutaneously once daily ❑
- FBC (platelets) to be checked on day 0 and day 1.
- Review VTE prophylaxis 3x weekly

NB. reduction of prophylactic dose NOT required for patients with renal impairment (eGFR <30 ml/min)

Discussion with patient regarding risk of VTE & risks/benefits of LMWH ❑

❑ **Acute Coronary Syndrome** should receive treatment dose Dalteparin

❑ **Suspected DVT or Pulmonary Embolism** should receive treatment dose Dalteparin, until excluded.

NB. treatment dose LMWH should be reduced by 20% if eGFR <30 ml/min – see ADTC 75

Write or attach label

CHI No .....

Surname: .....

Forename: ..... Sex: .....

DOB: .....

Impression • Differential Diagnosis • Problem List

DT

Management Plan

... investigations listed must be annotated in a way that makes it clear if suggested, requested or performed.

Example: *"CT- requested on PMS* ☑"; *"Urinalysis – awaited* ☐"

GMAus.

Mg added → 0.77

Pabrinex

Monitor for further signs bleeding – VTE prophylaxis not prescribed

All Patients

Blood results reviewed and printed:	☐
VTE prophylaxis assessed:	☐
Investigations requested:	☐
In-patient prescription chart complete:	☐

Considerations

Sepsis 6?	☐
Adults With Incapacity?	☐
DNA-CPR?	☐
HIV test?	☐

Name & grade (ID stamp): Dr Chris Cox GMC No 7670709

Signature:

Page: 3565

Ward: ED

Date: 13/12/20

Time: 04:40

ACUTE MEDICINE

Pneumonia

CURB65 Score

C	Confusion (4 point AMT ≤ 3)	1
U	Urea >7 mmol/L	1
R	Respiratory Rate >30/min	1
B	Systolic BP <90 mmHg	1
65	Age greater than 65	1

Score 0 - 1 = Mild = PO Abx
Score 2 = Moderate = IV Abx
Score ≥ 3 = Severe = IV Abx

Always refer to local antibiotic policy

Use clinical judgement (e.g. bilateral pneumonia, degree of hypoxia).

Pulmonary Embolism

Simplified Geneva score

Age >65 years	1
Previous DVT or PTE	1
Surgery or fracture in last month	1
Active malignancy (or cure <1yr)	1
Unilateral lower limb pain	1
Haemoptysis	1
Heart rate 75 to 94 bpm	1
Heart rate >94 bpm	+1

Score ≤ 2 → for D-Dimer
Score > 2 → not for D-dimer, for appropriate imaging eg V/Q or CTPA

Deep Vein Thrombosis

Modified Wells

Active malignancy (or Rx ≤ 6mo)	1
Paralysis or plaster	1
Bedridden >3/7	1
Vein tenderness	1
Entire swollen leg	1
Difference in calf >3cm	1
Unilateral oedema	1
Previous DVT	1
More likely diagnosis	-2

Score < 2, low risk, for D-dimer
Score ≥ 2, high risk, for Doppler ultrasound

Upper GI Bleed

Glasgow Blatchford Score

Criterion	Male	Female	Score
Hb (g/dL)	120-130	100-120	1
	100-120	-	3
	<100	<100	6
Urea (mmol/L)	6.5 - 8		2
	8 - 10		3
	10 - 25		4
	>25		6
Systolic BP	100 - 109		1
	90 - 99		2
	< 90		3
Pulse ≥ 100	Present		1
Melaena	Present		1
Syncope	Present		2
Liver	Present		2
CCF	Present		2

Score 0 – 1; consider early discharge
Score >6 = 50% likely need intervention

Alcoholic Hepatitis

Glasgow Alcoholic Hepatitis

Age	< 50	1
	≥ 50	2
WCC	< 15	1
	≥ 15	2
Urea	< 5	1
	≥ 5	2
INR	< 1.5	1
	1.5 - 2	2
	> 2	3
Bilirubin	< 125	1
	125 - 250	2
	> 250	3

If total > 9, consult Gastro about steroids

Maddrey's score

= (4.6 x (PT test - control)) + Bilirubin ÷17
(If total >32, consider steroids)

Acute Pancreatitis

Imrie Severity Score

PaO_2 < 7.9 kPa	1
Age > 55	1
WCC >15 x10^9/L	1
Calcium < 2 mmol/L	1
Urea >16 mmol/L	1
LHD > 600 IU or AST > 200 IU	1
Albumin < 32 g/L	1
Glucose > 10 mmol/L	1

If considering pancreatitis, request surgical review
If the score ≥ 3, severe pancreatitis likely: contact surgeons & consider Surgical HDU / ITU

Anion Gap

= $(Na^+ + K^+) - (Cl^- - HCO_3^-)$

Used to assess the contribution of unmeasured anions to acidosis. Normal range 10-20 mmol/L.

TIA Assessment

$ABCD_2$ Score

Age > 60	1
BP >140 / 90	1
Speech disturbance	1
Unilateral weakness	2
Duration 10-59 min	1
≥ 60 min	2
Diabetes	1

Score <4; start aspirin 300mg.
Score ≥4; start aspirin 300mg & specialist assessment <24h; carotid doppler / brain imaging.

Oxygen Therapy

BTS Guidance

No risk of chronic hypercapnic respiratory failure:
Aim sats 94 – 98%
If sats < 85% initially use trauma mask 15L

Risk of chronic hypercapnic respiratory failure/COPD
Aim sats 88 – 92%
Initially use Venturi mask 28%

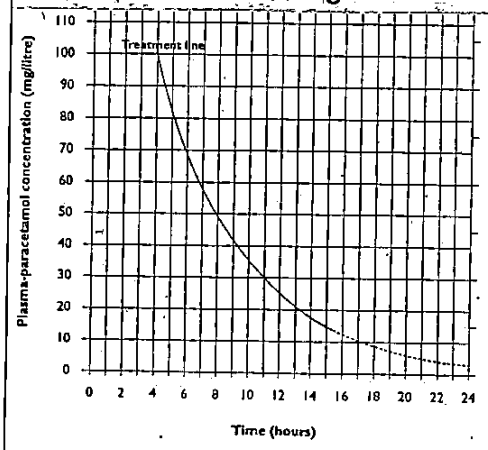
Non-Valvular AF anticoagulation

CHA_2DS_2 Vasc

Heart Failure	1
Hypertension	1
Age 65 - 74	1
Age ≥ 75	2
Diabetes	1
Previous TIA or stroke	2
Vascular disease	1
Female	1

If ≥1, for Warfarin
Consider LMWH & novel oral anti-coagulants.

Paracetamol Overdose guidance



Where level is above treatment line, give N-acetylcysteine (Parvolex)

Treatment with N-AC: (1) ascertain patient's weight and (2) use adult dosage table to determine the appropriate volume of N-AC to be added to the infusion fluid for each of the 3 infusion periods.

For full information refer to Toxbase & BNF:
Emergency treatment of poisoning > Specific drugs > Paracetamol.

Therapeutic excess:
Give N-AC if jaundice, hepatic tenderness, or ingested >150mg/kg in 24hrs.
Consider N-AC if ingested 75-150mg/kg in 24 hrs if glutathione deplete (eg. chronic debilitating illness, malnourished patients, ie. not eaten for a few days, eating disorders, cystic fibrosis, AIDS, cachexia, alcoholism, cirrhosis)

Write or attach label

CHI No .....

Surname: GALLOWAY

Forename: STEPHEN Sex: .....

DOB: 140665 0854

Consultant Opinion Date: 13/12/20 Time: 13:30 Ward: CAU 11 AC

SSM 1) ETOH WITHDRAWAL

2) ? MALAGNA.

ETOH X3.

COPD.

PMOH UGI BLEED.

IHD.

NEWS: (1) GMAWS 2→0.

(D)(N) (A)VPU.

°AO

QUEST: ↓ BS (U) BASE ~ OCC CAUSE.

SNT BSG

°JAUNDICE.

°SNG SLD.

BLOODS: HB 126 WCC 14·1 PLT 148 ↑LFTS. Ca/PO4/K+/Na+/Mg2+ OK.

ECG: SINUS TACHY. CXR: NIL NEW ↑(L) HEMID.

(A) 1). PARACETAMOL

2) PRN GMAWS

3) OBS GI BLEED - IF MALAGNA OR DROP HB/FU } OGD.

4) DCH.

GBENBRAC

EDD 16-FEB-21.

Dr PS Hodkinson
Consultant 4532387

ACUTE MEDICINE

Discharge / Allocate:

EDD: <24hr 24-72 hrs >72 hrs

Name (ID Stamp):

Signature:

Clinical Governance

Medicine Reconciliation complete	☐
VTE Prophylaxis Assessed & prescribed	☐
Antibiotics as per microbiology policy	☐
DNA-CPR status considered	☐
Escalation of care/ceiling of treatment considered	☐

Continuation

14/12/20 STH HUGHES WR
1032 ISSUES

① ALCOHOL WITHDRAWAL
- On Pabrinex / GMAWS

② ?UGIB
- U+6·8
Hb 126
CRP 18
Hasn't opened bowels yet today
Soft
Mildly tender

PLAN) Continue Pabrinex / GMAWS
Repeat Bloods

STH

15/12/20 CTORRENS COF.
10.45 Admitted 13/12/20 -/

① Alcohol withdrawal
- PRN Diazepam
13/12 - 40mg diazepam
14/12 : 40mg diazepam

② ?UGI bleed
- 2/52 of melena. Denies haematemesis
- not opened bowels since admission

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

Continuation

Cont o/E Well. NEWS 0.
Tremulous.
Abdo soft, non tender

Plan ① Pabrinex / GMAWS - cold stop pabrinex 16/12
② Bloods
③ Monitor bloods

Dr Liam Torrens
Clinical Development Fellow
GMC 7608270 Page.....
3229.

16/12/20 CON WR 1047

Stated "dark brown" stool last night — not witnessed

Hb 126. Ur ↔ } yesterday

P/ Rpt blds today
Stool chart
AIC liaison
If no melena, blds ↔ ? (H) later for OP OGD

SMITH

ACUTE MEDICINE

Continuation

16/12/20 - Alcohol liaison. Attended today, however no private space available. Brief chat at bedside. Alcohol information pack provided. Stephen happy for ALN to make telephone contact once home. Discharged from ALN point of view

Lorraine Hope ALN

16/12/2020 1851 No further episodes of malaena. Not scored a GMMWS for 48° hours NEWS-1 HR. Patient happy to go home. OGD requested as OP Hb 132. LFT's improved.

Angela [illegible]

ALCOHOL LIAISON REFERRAL FORM

Is Patient Aware of Referral: YES			
Date of Referral:	14/12/20	Hospital No	1406650854
Patient's Name:	Stephen Galloway	Date of Birth: CHI Number:	14/06/65
Address:	28 Redburn Place Irvine		
GP:			
Referring Consultant:	Dr Hodkinson	Station/Ward:	CAU ambulatory care
Date of Admission:	13/12/20	Reason for Referral:	ALCOHOL WITHDRAWEL
STATUS: Informal:		Informal	
Medication:	GMAWS	Alcohol use/drugs (what, how much, Last used):	2litresa day
CIWA score (over 20 not fit)	SCORING	Medically fit:	fit
Summary of circumstances leading to admission:		*alcohol withdrawal, malena, hallucinations*	
Any other agencies involved:		NONE KNOWN	
Referring Doctor/Nurse:		SN STRUTHERS	
Page/Ward Number:		EX-27467	
Expected date of discharge:		UNKNOWN	
Send to : Clinical MentalHealth LiaisonPsychiatry A&A@aapct.scot.nhs.uk			

Write or attach label

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158
Date of Birth

Dr Shah STA0238

DATE

4/5/19 wgt 71.6kgs

MCAllen

M Dunn

u/sound (N)

MEDICAL

DATE

Patient Information		Date:	21/01/2019
STEPHEN GALLOWAY		Incident Number:	PA005255128
Age/Gender:	53y Old Male	Incident Type:	URG
Address:		Incident Location:	28 REDBURN PLACE IRVINE, KA12 9BH
DOB:	14/06/1965		
CHI:	1406650854		
Ethnicity:			

Scottish Ambulance Service

Presenting Complaint

DOCTORS CALL.

Additional Comments

STEVIE WENT DOWN TO SEE THE DOCTOR AROUND LUNCH TIME TODAY AND SHE ARRANGED FOR AN AMBULANCE TO TAKE STEVIE UP TO XHOUSE HOSPITAL CAU FOR FURTHER INVESTIGATION. NO PAPERWORK WAS SUPPLIED BY THE DOCTOR.

PATIENT ASSESSMENT

AVPU	Alert		<C>	No			
A	Clear						
B							
C	Pulse Rate	BP	Cap Refill	ECG Rhythm			
	104	156/94	<=2 Secs	Sinus Tachy			
	Rhythm	Arm	Central/Peripheral	ECG			
	Reg	Left		3 Lead			
D	GCS	Eyes	Voice	Motor	PEARL		
	15	Spontaneously (4)	Orientated (5)	Obeys Commands (6)	Yes		
E							

Observations

Time	P	RR	BP	SpO2	CR	GCS	AVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
15:29	98	18	152/92	97	<=2s	15	Alert		37.1	9.3	Sinus Tachy				E0024228
15:05	104	18	156/94	95	<=2s	15	Alert		37.1	9.3	Sinus Tachy				E0024228

NEWS

Time	Clinical Risk	NEWS
15:29	LOW Immediate Clinical Risk. Treat as per Clinical Practice Guidelines including considering the use of alternative pathways (if appropriate and available).	1
15:05	LOW Immediate Clinical Risk. Treat as per Clinical Practice Guidelines including considering the use of alternative pathways (if appropriate and available).	2

HISTORY

AMPLE

Allergies	None
Medication	NONE
Past Medical History	UNKNOWN
Last Eaten	~~Within Past Hour~~ LAST TUESDAY

CLOSE RECORD

Treatment On Scene	Non Emergency

Conveyance

Transport To Hospital	Normal driving	Pre Alert	No

INCIDENT LOG

Time Call Received	12:48	Allocated	14:52	Mobile	14:54

First Resource On Scene		Crew On Scene	15:08	Crew Left Scene	15:16
Crew At Hosp		Receiving Hospital	CROSSHOUSE HOSPITAL	Clear Time	

Crew ID	Crew Grade	Driver
E9887898	Ambulance Care Assistant	YES
E0024228	Ambulance Technician	NO

NHS Ayrshire & Arran

CAU Referral Information

Date: 21/11/19. Time call taken: 1240.

Name call handler: JMcleod.

CHI 1406650854 Age

Surname Galloway

Forename Stephen

GP name/practice Inre.

Referral source:

ED to: Acute Med/ED Ambulatory pathway **ED Time of arrival:**

GP Letter with **patient/mailbox/fax** from **Home/NH**

Other please state: Ambulance **Y/N**

CLINICAL ALERT PRESENT

RED FLAG ✓

Reason for referral: PMX/AHC is (ve)

Pneumonia ? Sepsis.

Observations NEWS= or [RR 24 SpO2 91-95/Sup' O2 Temp 38.5 HR 116. BP N . AVPU]

Delirium Y/N Planned destination:

Specific actions required on arrival:

Time of arrival IAA: 1600 . **NEWS=** 2 . **Immediate review required Y/N** **THINK SEPSIS 6**

4AT= **Frailty score =** **Mental Health Risk Assessment** (if required)=

Comments: 1/52 hx cough ↓ appetite since tuesday . . Productive since yesterday. Spo. 94%. DIW or pins no need for O2 Supplement.

Time referral to stroke team (if applicable):

Does patient have conditions that require medications pending medical review? Y/N

(Myasthenia Gravis Parkinson's disease Insulin dependent diabetes Seizures Steroid dependency/Addisons)

Review clinical alert printouts if present

Next of Kin: Power of Attorney:

Patient suitable for red dot chairs Y/N Name of assessor JMcleod Time 1640

PVC – think **DRIFT** (Diagnostics, Resuscitation, IV medication, Fluids, Transfusion) yes.

	Required	Performed		Required	Performed
U&Es	✓		ABG		
FBC	✓		LFTs	✓	
Glucose	✓		TnT		
Coag	✓		ECG	✓	
Lactate			CXR		
CRP	✓		Urine		
VBG			Other tests		
Blood Cultures	✓		Bone profile		

Brief clinical summary of review or events in IAA:

FCUS
30F
USS

Name assessor ..... Role ..... Time review .....

NHS Ayrshire & Arran

(14)

NURSING NOTES

Write or attach label
HCR No: .....
CHI No: .....
Surname: .....
Forename: ..... Sex: .....
Address: .....
.....
Date of Birth: .....

31/08

AmbuCare

DATE	
	Steven Galloway (53)
21/1	A+E ? chest inf cough SOB — TAG - pdiceaus
	anxiety
NO NOK	LRTI ? Undig COPD — depression
	Bloods alone U+E's off — ↑ BP
	steroids. — alc XS.
	oral ABTS — 4 ATO
	IV fluids — indep
	Blood cultures if pyrexia — SC
	skin intact
	Lives alone.
Am-	Urine - White top + Biochem form
	osmolarity ☑
	Bloods- ☑
	NEWS (2) SpO2 94, UR 92
	RV ☐

DATE	

NHS Ayrshire & Arran

Acute Medicine Assessment Proforma

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

Date: 21/02/19	Time: 1610
Referral source: GP	Receiving Consultant: WILLIAMS

Presenting Complaint

53 ♂ ½ s2 hx of ↑SCB
Productive cough - yellow / brown sputum.
No chest pain
↓ Appetite
Met / sweaty fevers
No myalgia / N + V
Smoker
No calf swelling / tenderness.

Past Medical History

Anxiety
Depression
Prev HTN
Alcohol excess.

ACUTE MEDICINE

Multidisciplinary Medicines Reconciliation

Must be started by admitting Clinician within 24 hours

Source of information (use at least two sources) (Tick)

Patient	☑	Emergency Care Summary	☑
Relative / Carer	☐	Nursing Home Chart	☐
Patient's Own Drugs	☐	Previous Discharge Letter	☐
GP Referral Letter	☐	Repeat Prescription	☐
GP Practice	☐	Other (please specify)	☐

Admission Medicines			Action Note: Unless otherwise indicated below, medicines should be continued on prescription sheet				
Name, Form, Route (specify if not oral)	Dose	Frequency e.g. 3X	Suspend	Amend	Stop	Comments (if medicine suspended, amended stopped or inaccurate)	Pharm initials if change
MI regular							

OTC / Herbal / Homeopathic / Illicit substances	Further information e.g. compliance aid, recent discontinued medicines

Adverse Reactions / Allergies Non known ☑ or

Medicines / Substance	Reaction

Are you satisfied this medication history is complete and accurate? YES ☐ NO ☐

If NO what further action is necessary (Contact GP etc) ..... Tick when resolved ☐

Pharmacist review signature ..... Date/Time ..... Beep No .....
(Initial changes / additions above)

Write or attach label

CHI No .....

Surname: .....

Forename: ..... Sex: .....

DOB: .....

Family History

Social History (As relevant)

Works as:

Lives with: Alone

Mobilises using: (I)

Home Care: -

Family Support: -

Recent Travel: -

Functional Capacity: Normally (I)
(eg. climb a flight of stairs?)

Alcohol (units/wk): Prev excess nil for 6 wks.

Smoker: (Yes) / No / Ex 18 x day 40 years. Mi days.

Systematic Enquiry (As relevant)

No recent weight loss / ~~xxxx~~

Weight loss / Appetite
Cardiovascular
Respiratory
Gastrointestinal
Urinary
Neurological
Musculoskeletal
ENT / Eyes
Skin
Endocrine
Gynaecology
Mental Health

Physical Activity screening:

Does the patient undertake 30 minutes of moderate physical activity 5 days per week?

Yes ☐ No ☐ If no, consider referral to local council physical activity advice program

ACUTE MEDICINE

General Examination

Temp: 36·5 Pulse: RR: 17

SpO_2: 94 % FiO_2: AIR (mask/NP)

BP - Lying: 165 / 90

Standing$_{(1min)}$: /

Calves: Nil

Delirium and Cognitive Assessment

4AT score _____ Use if over 65 or confused

Nursing staff will do this on admission; transcribe from their admission document.

The 4AT score helps distinguish delirium from cognitive impairment. Delirium is more likely in the acute setting.

Score ≥ 4: delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: unlikely delirium or cognitive impairment

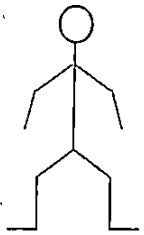
If ≥4 then commence Delirium Pathway

Cardiovascular Examination

HS: I...II...O

Heaves / Thrills

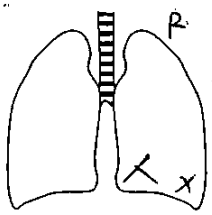
Pulses:



JVP:

Oedema: Nil

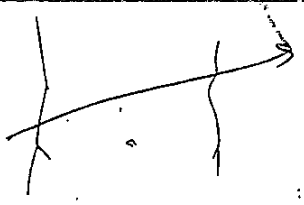
Respiratory Examination



Few crep (R) base.

Peak flow:

Abdominal Examination



SNT.

Bowel sounds:

PR:

General Neurological Examination

GCS: 15 /15 (E___/4, M___/6, V___/5)

Gait? Tremor? Meningism?

Peripheral and Cranial Nerve Examination

Grossly Intact.

	RUL	LUL	RLL	LLL
Pronator drift			-	-
Tone				
Power				
Reflexes				
Sensation				
Co-ordination				
Plantar reflexes				

Write or attach label

CHI No .....

Surname: .....

Forename: ..... Sex: .....

DOB: .....

Improving Sepsis Survival: Use if infection suspected *and* SIRS ≥ 2 or MEWS ≥ 4

Systemic Inflammatory Response Syndrome

- Temp >38° or < 36° ☐
- White cell count >12 or < 4 ☐
- Heart rate >90 min^{-1} ☐
- Respiratory rate > 20 min^{-1} ☐
- Acutely altered mental state: (4-Point AMT ≤ 3) ☐
- Bedside glucose >7.7 $mmoll^{-1}$ (without Diabetes) ☐

Sepsis Six

Must be complete within 1 hour suspected sepsis or SIRS criteria met.

1. **Antibiotics** (IV) as per local guidelines ☐
2. **Cultures** (Blood and relevant) ☐
3. **Oxygen** to achieve Sats >94%& ≤ 98% ☐
4. **Fluid** (IV) (500ml / hour or 20ml/kg stat if organ dysfunction present) ☐
5. **Lactate** ☐
6. **Monitor urine output** (Catheterise if organ dysfunction apparent) ☐

No obvious source? Check throat, ears, joints, pressure sores, IV cannula/central line sites, remove dressings, consider endocarditis or foreign body (e.g. tampon). Consider possible non-infective cause (e.g. pancreatitis, transfusion reaction, trauma and burns).

If Severe Sepsis suspected (Lactate ≥ 4mmoll^{-1}) contact senior medic on-call /ERT/H@N, consider transfer to Medical HDU; Medical High Care or ITU referral. Septic patients require regular review by senior medic on-call /ERT/H@N; patient must be handed over accordingly.

Relevant Investigations

ECG: SR

CXR: Awaited

Urinalysis:

Leucocytes:
Nitrites:
Protein:
Blood:
Glucose:
Ketones:

Relevant Bloods: Awaited

ABGs:

ACUTE MEDICINE

Adult Medical Assessment Venous Thrombo-embolism (VTE) Prophylaxis Tool

[ADTC 213/2]

Do Not Use in Acute Stroke

Risks for thromboembolism (tick if apply)

- ☐ Age >60 years
- ☐ Active cancer or cancer treatment
- ☐ Any significant medical illness
  (e.g. cardiac, metabolic, endocrine, or respiratory disease; acute infection; inflammatory condition)
- ☐ Critical care admission e.g. HDU/ITU
- ☐ Dehydration
- ☐ Known thrombophilia
- ☐ Obesity (BMI > 30)
- ☐ Personal history or first degree relative with a history of VTE
- ☐ Pregnancy or ≤ 6 weeks post-partum
- ☐ Significantly reduced mobility for 3 days or more
- ☐ Use of hormone replacement therapy
- ☐ Use of oestrogen-containing contraceptive therapy

→ **No Risk Factors** ☐

→ **No prophylaxis required**
- Review decision 3x weekly

↓ **1 or more Risk Factors**

Contraindications to Dalteparin (tick if apply)

- ☐ **Lumbar Puncture**/Epidural/Spinal Anaesthesia in previous 4 hours *or expected within next 12 hours*
- ☐ Any other procedure with high bleeding risk expected during this admission (including neurosurgery, spinal or eye surgery)
- ☐ Active bleeding
- ☐ Acute stroke
- ☐ Acute gastro-duodenal ulcer
- ☐ Acquired bleeding disorders e.g. acute liver disease
- ☐ Previous Heparin Induced Thrombocytopaenia (HIT)
- ☐ Thrombocytopaenia (Platelets $<75 \times 10^9$/L)
- ☐ Concurrent use of **any** other anticoagulants (e.g. Warfarin)
- ☐ Uncontrolled hypertension >230/120 mmHg
- ☐ Untreated inherited bleeding disorders
- ☐ Any other concern (document in case notes)

→ **Any Contraindications** ☐

→ **Do not prescribe LMWH**
- Consider Anti Embolic stockings.
- Review decision 3x weekly

↓ **No Contraindications** ☐

Please prescribe Dalteparin 5000 units subcutaneously once daily ☐

- FBC (platelets) to be checked on day 0 and day 1.
- Review VTE prophylaxis 3x weekly

NB. reduction of prophylactic dose NOT required for patients with renal impairment (eGFR <30 ml/min)

Discussion with patient regarding risk of VTE & risks/benefits of LMWH ☐

☐ **Acute Coronary Syndrome** should receive treatment dose Dalteparin

☐ **Suspected DVT or Pulmonary Embolism** should receive treatment dose Dalteparin, until excluded.

NB. treatment dose LMWH should be reduced by 20% if eGFR <30 ml/min – see ADTC 75

Write or attach label

CHI No .....

Surname: .....

Forename: ..... Sex: .....

DOB: .....

Impression • Differential Diagnosis • Problem List

(1) 2 RTI

(2) ? Undiagnosed COPD

anagement Plan

All investigations listed must be annotated in a way that makes it clear if suggested, requested or performed.
Example: *"CT- requested on PMS* ☑"; *"Urinalysis – awaited* ☐"

(1) Bids

(2) ECG

(3) CXR

(4) if bids / XR okay
- ? (N) + oral antibiotics
+ O/P Spirometry

(5) ? Needs F/U imaging
CT given haemoptysis

(6) Sputum C+S ☐

ACUTE MEDICINE

All Patients	
Blood results reviewed and printed:	☐
VTE prophylaxis assessed:	☐
Investigations requested:	☐
In-patient prescription chart complete:	☐
Considerations	
Sepsis 6?	☐
Adults With Incapacity?	☐
DNA-CPR?	☐
HIV test?	☐

Name & grade (ID stamp): Dr Clare Doherty

Signature:

Page: 3512

Ward: CAU

Date: 21/01/19

Time: 16:30

Pneumonia

CURB65 Score

C	Confusion (4 point AMT ≤ 3)	1
U	Urea >7 mmol/L	1
R	Respiratory Rate >30/min	1
B	Systolic BP <90 mmHg	1
65	Age greater than 65	1

Score 0 - 1 = Mild = PO Abx
Score 2 = Moderate = IV Abx
Score ≥ 3 = Severe = IV Abx

Always refer to local antibiotic policy

Use clinical judgement (e.g. bilateral pneumonia, degree of hypoxia).

Pulmonary Embolism

Simplified Geneva score

Age >65 years	1
Previous DVT or PTE	1
Surgery or fracture in last month	1
Active malignancy (or cure <1yr)	1
Unilateral lower limb pain	1
Haemoptysis	1
Heart rate 75 to 94 bpm	1
Heart rate >94 bpm	+1

Score ≤ 2 → for D-Dimer
Score > 2 → not for D-dimer, for appropriate imaging eg $\dot{V}/\dot{Q}$ or CTPA

Deep Vein Thrombosis

Modified Wells

Active malignancy (or Rx ≤ 6mo)	1
Paralysis or plaster	1
Bedridden >3/7	1
Vein tenderness	1
Entire swollen leg	1
Difference in calf >3cm	1
Unilateral oedema	1
Previous DVT	1
More likely diagnosis	-2

Score < 2, low risk, for D-dimer
Score ≥ 2, high risk, for Doppler ultrasound

Upper GI Bleed

Glasgow Blatchford Score

Criterion	Male	Female	Score
Hb (g/dL)	120-130	100-120	1
	100-120	-	3
	<100	<100	6
Urea (mmol/L)	6.5 - 8		2
	8 - 10		3
	10 - 25		4
	>25		6
Systolic BP	100 - 109		1
	90 - 99		2
	< 90		3
Pulse ≥ 100	Present		1
Melaena	Present		1
Syncope	Present		2
Liver	Present		2
CCF	Present		2

Score 0 – 1; consider early discharge
Score >6 = 50% likely need intervention

Alcoholic Hepatitis

Glasgow Alcoholic Hepatitis

Age	< 50	1
	≥ 50	2
WCC	< 15	1
	≥ 15	2
Urea	< 5	1
	≥ 5	2
INR	< 1.5	1
	1.5 - 2	2
	> 2	3
Bilirubin	< 125	1
	125 - 250	2
	> 250	3

If total > 9, consult Gastro about steroids

Maddrey's score

= (4.6 x (PT test - control)) + Bilirubin ÷17
(If total >32, consider steroids)

Acute Pancreatitis

Imrie Severity Score

PaO_2 < 7.9 kPa	1
Age > 55	1
WCC >15 x10^9/L	1
Calcium < 2 mmol/L	1
Urea >16 mmol/L	1
LHD > 600 IU or AST > 200 IU	1
Albumin < 32 g/L	1
Glucose > 10 mmol/L	1

If considering pancreatitis, request surgical review

If the score ≥ 3, severe pancreatitis likely: contact surgeons & consider Surgical HDU / ITU

Anion Gap

= $(Na^+ + K^+) - (Cl^- - HCO_3^-)$

Used to assess the contribution of unmeasured anions to acidosis. Normal range 10-20 mmol/L.

TIA Assessment

$ABCD_2$ Score

Age > 60	1
BP >140 / 90	1
Speech disturbance	1
Unilateral weakness	2
Duration 10-59 min	1
≥ 60 min	2
Diabetes	1

Score <4; start aspirin 300mg.

Score ≥4; start aspirin 300mg & specialist assessment <24h; carotid doppler / brain imaging.

Oxygen Therapy

BTS Guidance

No risk of chronic hypercapnic respiratory failure:
Aim sats 94 – 98%
If sats < 85% initially use trauma mask 15L

Risk of chronic hypercapnic respiratory failure/COPD
Aim sats 88 – 92%
Initially use Venturi mask 28%

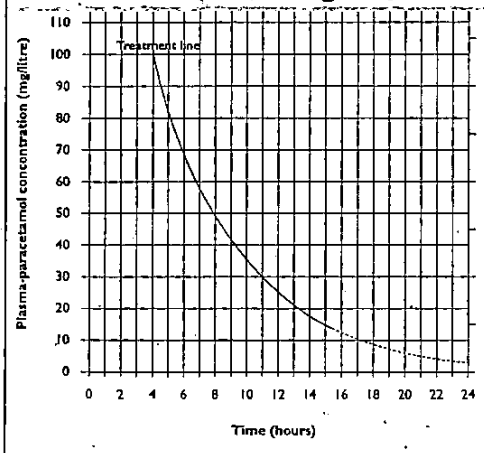
Non-Valvular AF anticoagulation

CHA_2DS_2 Vasc

Heart Failure	1
Hypertension	1
Age 65 - 74	1
Age ≥ 75	2
Diabetes	1
Previous TIA or stroke	2
Vascular disease	1
Female	1

If ≥1, for Warfarin
Consider LMWH & novel oral anti-coagulants.

Paracetamol Overdose guidance



Where level is above treatment line, give N-acetylcysteine (Parvolex)

Treatment with N-AC: (1) ascertain patient's weight and (2) use adult dosage table to determine the appropriate volume of N-AC to be added to the infusion fluid for each of the 3 infusion periods.

For full information refer to Toxbase & BNF:
Emergency treatment of poisoning > Specific drugs > Paracetamol.

Therapeutic excess:

Give N-AC if jaundice, hepatic tenderness, or ingested >150mg/kg in 24hrs.

Consider N-AC if ingested 75-150mg/kg in 24 hrs if glutathione deplete (eg. chronic debilitating illness, malnourished patients, ie. not eaten for a few days, eating disorders, cystic fibrosis, AIDS, cachexia, alcoholism, cirrhosis)

Write or attach label

CHI No .....

Surname: .....

Forename: ..... Sex: .....

DOB: .....

Consultant Opinion Date: Time: Ward:

EMCAM 21/11/19 17:55 CNL

53yr old male
- Anxiety / Depression
- HTN
- Alcohol
- Asthma as a child

Unwell 5/c - 1152 - felt he had a cold - cough & SOB ? wheezy
- initially non-productive now ? ppt
clear phlegm
- no haemoptysis
- no chest pain
- felt feverish
- diarrhoea stable wheeze & past fortnight
- reduced appetite
- no recent travel / incidence
- no hand ons Rx

CVS No clubbing / lymphadenopathy

Mild wheeze bilaterally RR 17 Sats 94%

ITS - 1 ↑ WCC - CRP 16 ↓ 9 - ↓ LFTs - CXR NAD

Resp
Bilat Chicken
- similar to previous

ECG
Sinus 99/min

Bloods
awaited

SIRS

Imp - ? exacerbation COPD (underlying)
- ? ~~AE~~ non-infective

Plan - await bloods
- Steroid ? IV ABx + prn Salbutamol inhaler
- CXR Spiro
- ECG ↓ LVF
- ? Nebs advice sine
- ? If ↓ bloods on

→ PTC

Discharge / Allocate:

EDD: <24hr 24-72 hrs >72 hrs

Name (ID Stamp): EMCAM

Signature: 7080381

Clinical Governance

Medicine Reconciliation complete	☐
VTE Prophylaxis Assessed & prescribed	☐
Antibiotics as per microbiology policy	☐
DNA-CPR status considered	☐
Escalation of care/ceiling of treatment considered	☐

ACUTE MEDICINE

Continuation

r pr has electronic has r needs to be home by 7pm - informed police + told to contact. ehs - attempted but only number i can since status address are closed

Blocks

hcc 11.1	ha b 18	LPFS/ca ⊖
ths lhc	h 4.1	
cnpala	weak-c	
	clear 86	
	earn 76c	

⇒ 1. Mike needs 24hrs during
Add amer - PC + 18 cannel/Peria
⇒ IC.
bc id pseria
Sputum CFS id productive
Urine/plasma ha tesmdaily
TFT
Stay in shira overnight + push
oral
pica/salbutamol
or spiro/ventolin as planned

n'Aum

Chest Inf - on oral Amox 5 days.
Temp ↓. CRP 172.
Chest clear. CXR - clear lungs.
Stay 3 days c/b/w ↓ 6/52

Ikj Cont oral Ax
Wait for culture.
(Amox)

NM

Write or attach label

CHI No .....

Surname: .....

Forename: ..... Sex: .....

DOB: .....

Continuation

23/1/19 — CT2 — W12

(53) → ↑ 1 week Hx. of Tring SOB.

↳ Cough — yellow sputum

↳

+ ve Chest pain.

B/L ↑ AIN ✓ XJ. ⇒ Last Alcohol drink was 6/52 ago

↑ Anxiety / Depression

↑ Smoker.

- Now better
- was in day surgery ⇒ moved to ward 31 as ??

PT. ⇒ ↑.

Last Alcohol drinking was 6/52 ago

- No fever
- No Clp. ✗ no hemoptysis
- Today: ↑ well
  - ↓ cough SOB
  - Cough better

Obs ↔ ✓

Chest: few crepes ✓ ↓

ACUTE MEDICINE

CAP bd.

Continuation

No clinical DT,

Plan:
1. Home today
2. Cont. full course of ABx
3. Cont. steroids
4. G.P. to check blood pressure
5. advise to stop smoking
6. G.P. follow up.

NHS Ayrshire & Arran

CAU Referral Information

Date: 4/1/18 Time call taken: 10.10

Name call handler: TP

CHI 1406650854 Age 53

Surname Galloway

Forename Steven

GP name/practice Irvine

Referral source:

ED to: Acute Med/ED Ambulatory pathway **ED Time of arrival:**

(GP) Letter with **patient/mailbox/fax** from **Home/NH**

Other please state: Ambulance **Y/N**

CLINICAL ALERT PRESENT

RED FLAG

Reason for referral: Abdo Pain

↓ alcohol over past

Alchol ex

11+ Gin daily

Cut down hen 2lb

Abdo Soft.

Seizures.

Observations NEWS= or [RR SpO2 96 Sup' O2 Temp 34.2 HR 120. BP 177/98 AVPU]

Delirium Y/N Planned destination:

Specific actions required on arrival:

Time of arrival IAA: 1055 **NEWS=** **Immediate review required Y/N** **THINK SEPSIS 6**

4AT= **Frail** (as per screening tool) **Y/N** **Mental Health Risk Assessment** (if required)=

Comments:

Had tingling in hands. Attended ADU. States he possibly had seizure yesterday. Last had drink (alcohol) at half 5 last night. Denies any chest pain.

Time referral to stroke team (if applicable):

Does patient have conditions that require medications pending medical review? Y/N

(Myasthenia Gravis Parkinson's disease Insulin dependent diabetes Seizures Steroid dependency/Addisons)

Review clinical alert printouts if present

Next of Kin: Power of Attorney:

Patient suitable for red dot chairs Y/N Name of assessor.....Time.....

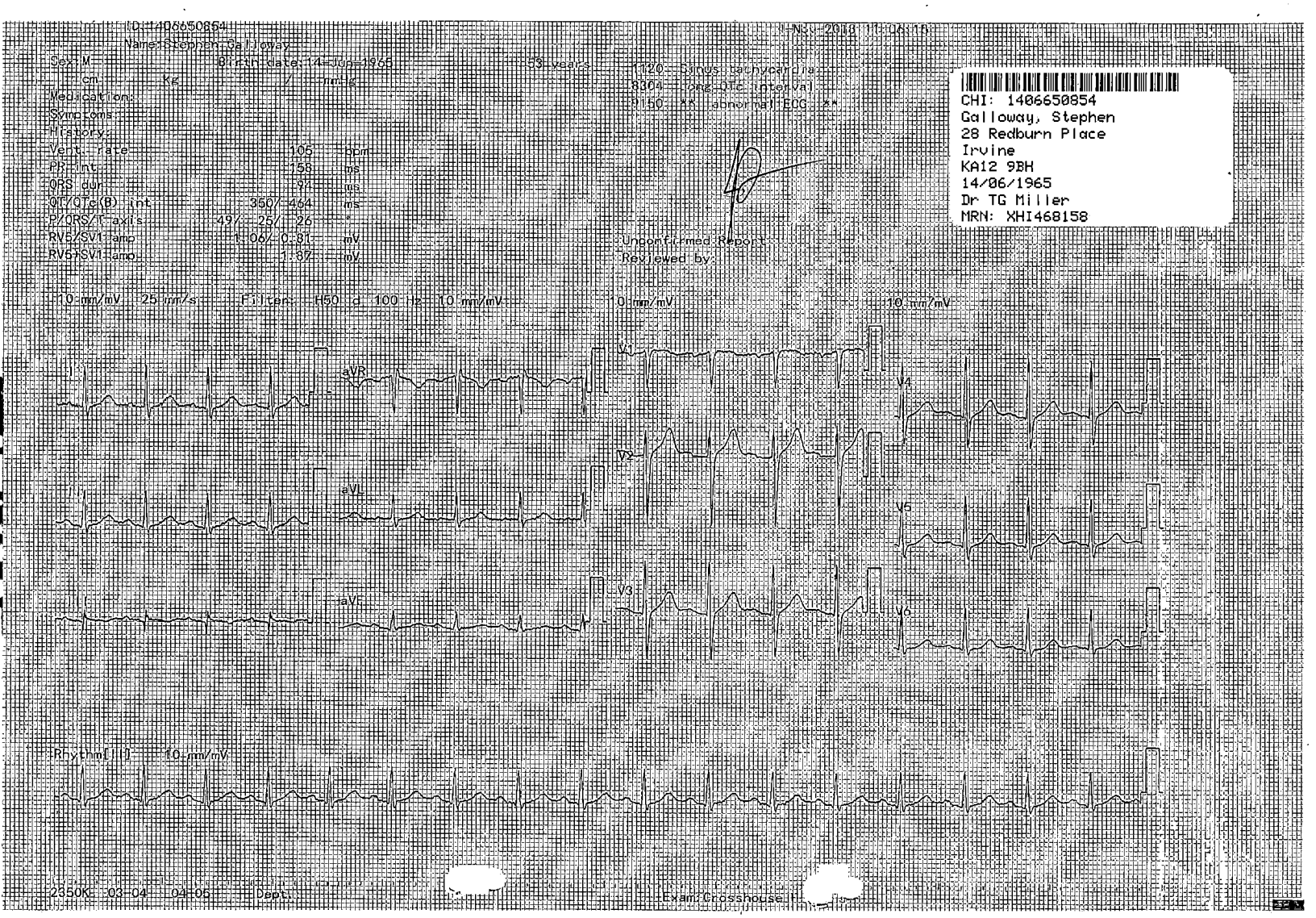
PVC – think **DRIFT** (Diagnostics, Resuscitation, IV medication, Fluids, Transfusion)

	Required	Performed		Required	Performed
U&Es	✓	JL	ABG		
FBC	✓	JL	LFTs	✓	JL
Glucose	✓	JL	TnT		
Coag	✓	JL	ECG	✓	LD.
Lactate			CXR		
CRP	✓	JL	Urine		
VBG			Other tests	Bone profile	JL
Blood Cultures					

Brief clinical summary of review or events in IAA:

Name assessor ..... Role ..... Time review .....

ID: 1406650854
Name: Stephen Galloway
Sex: M
Birth date: 14-Jun-1965
53 years
cm
Kg
mm Hg
Medication:
Symptoms
History:



NSC 20110 11:04:10

R120 Sinus tachycardia
B304 Long QTc interval
R150 ** abnormal ECG **

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

2350K 03-04 04-05 Dept:
Exam/Crosshouse

NHS Ayrshire & Arran

Acute Medicine Assessment Proforma

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

Date: 04/11/2018	Time: 1250
Referral source: GP	Receiving Consultant: MANUEL

Presenting Complaint

53 ♂ 1) Abdo pain

2) Alcohol withdrawal

Drinks 1-1.5 L spirits/day

Vomiting yesterday (°bloody) + watery diarrhoea (°bloody °melaena)

Pain crampy - non-localised

↑/↓ fx

Feels tremulous like withdrawing from alcohol

Past Medical History

Alcohol withdrawal

STA5225PS

ACUTE MEDICINE

Multidisciplinary Medicines Reconciliation

Must be started by admitting Clinician within 24 hours

Source of information (use at least two sources) (Tick)

Patient	☑	Emergency Care Summary	☑
Relative / Carer	☐	Nursing Home Chart	☐
Patient's Own Drugs	☐	Previous Discharge Letter	☐
GP Referral Letter	☐	Repeat Prescription	☐
GP Practice	☐	Other (please specify)	☐

Admission Medicines			Action Note: Unless otherwise indicated below, medicines should be continued on prescription sheet				
Name, Form, Route (specify if not oral)	Dose	Frequency e.g. 3X	Suspend	Amend	Stop	Comments (if medicine suspended, amended stopped or inaccurate)	Pharm initials if change
LANSOPRAZOLE	30mg	OD					
THIAMINE	100mg	TID					
TADALAFIL	5mg	OD					
See ECS							
Natalie Sharp							
Pharmacy Technician							
GPhC 5016705							

OTC / Herbal / Homeopathic / Illicit substances	Further information e.g. compliance aid, recent discontinued medicines

Adverse Reactions / Allergies Non known ☐ or

Medicines / Substance	Reaction

Are you satisfied this medication history is complete and accurate? YES ☐ NO ☐

If NO what further action is necessary (Contact GP etc) ..... Tick when resolved ☐

Pharmacist review signature ..... Date/Time ..... Beep No .....

(Initial changes / additions above)

Patient Name	CHI	Date Of Birth	Age
Stephen Galloway	1406650854	14/06/1965	53

Source of Information

Patient	✓	Relative / Carer		Patient's Own Drugs		GP Letter		GP Practice	
Care home / MAR Chart		Previous Discharge Letter		Repeat Prescription Slip		Community Pharmacy		Other (Please State)	

Allergy Description	Date Recorded	Comments
NKA.		

Acute Medication (including those greater than 30 days)

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Continue	Withhold	Stop	Comments

Repeat Medication

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Continue	Withhold	Stop	Comments
✓	Tadalafil	5 mg Tablets	ONE TAB DAILY		20-Sep-2018	20-Sep-2018					
✓	Lansoprazole	30 mg Capsules (Gastro-Resistant)	ONE TO BE TAKEN EACH DAY		21-Feb-2014	17-Aug-2018					PRN
✓	Thiamine Hydrochloride	100 mg Tablets	ONE TO BE TAKEN THREE TIMES A DAY		17-Aug-2018	17-Aug-2018					
OTC - Nil											

Patient Name	CHI	Date Of Birth	Age
Stephen Galloway	1406650854	14/06/1965	53

Repeat Medication

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Continue	Withhold	Stop	Comments

Compliance Device	Name and telephone number for community pharmacy
NIL	

Completed by	Designation	Grade	Date	Time	Contact Number
Natalie Sharp	PharmSC		5/11/18	14:24	#3085

Reviewed by	Designation	Grade	Date	Time	Contact Number
			06/11/18	09:25	

Marcella Howie-Volpe
Pharmacist
GPhC 2207646

Write or attach label

CHI No .....

Surname: .....

Forename: ..... Sex: .....

DOB: .....

Family History

Social History (As relevant)

Works as:

Lives with:

Mobilises using:

Home Care:

Family Support:

Recent Travel:

Functional Capacity:
(eg. climb a flight of stairs?)

Alcohol (units/wk): 300 + a week **Smoker:** Yes / No / Ex

Systematic Enquiry (As relevant)

Weight loss / Appetite
Cardiovascular
Respiratory
Gastrointestinal
Urinary
Neurological
Musculoskeletal
ENT / Eyes
Skin
Endocrine
Gynaecology
Mental Health

Physical Activity screening:

Does the patient undertake 30 minutes of moderate physical activity 5 days per week?

Yes ☐ No ☐ If no, consider referral to local council physical activity advice program

ACUTE MEDICINE

General Examination

Temp: 37.2 Pulse: 115 RR: 16

SpO_2: 97% FiO_2: A (mask/NP)

BP - Lying: 195/92

Standing(1min): /

Calves:

Delirium and Cognitive Assessment

4AT score _____ Use if over 65 or confused

Nursing staff will do this on admission; transcribe from their admission document.

The 4AT score helps distinguish delirium from cognitive impairment. Delirium is more likely in the acute setting.

Score ≥ 4: delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: unlikely delirium or cognitive impairment

If ≥4 then commence Delirium Pathway

Cardiovascular Examination

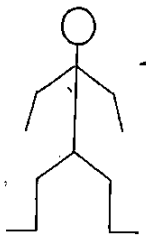
HS: I + II + 0

Heaves / Thrills X

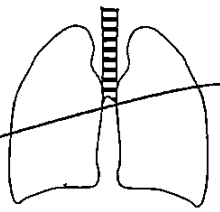
JVP: ⊘

Oedema: X

Pulses:



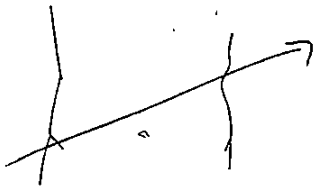
Respiratory Examination



Good AE
°Added
Calves SNT

Peak flow:

Abdominal Examination



SNT
BS ⊘
°masses

Bowel sounds:

PR:

General Neurological Examination

GCS: 15 /15 (E 4 /4, M 6 /6, V 5 /5)

Gait? Tremor? Meningism?

CN I → XII ⊘
tremulous
°nystagmus
°dysdiadochokinesis
°past pointing

Peripheral and Cranial Nerve Examination

	RUL	LUL	RLL	LLL
Pronator drift			-	-
Tone				
Power				
Reflexes				
Sensation				
Co-ordination				
Plantar reflexes				

Write or attach label

CHI No .....

Surname: .....

Forename: ..... Sex: .....

DOB: .....

Improving Sepsis Survival: Use if infection suspected *and* SIRS ≥ 2 or MEWS ≥ 4

Systemic Inflammatory Response Syndrome

- Temp >38° or < 36° ☐
- White cell count >12 or < 4 ☐
- Heart rate >90 min^{-1} ☐
- Respiratory rate > 20 min^{-1} ☐
- Acutely altered mental state: (4-Point AMT ≤ 3) ☐
- Bedside glucose >7.7 $mmoll^{-1}$ (without Diabetes) ☐

Sepsis Six

Must be complete within 1 hour suspected sepsis or SIRS criteria met.

1. **Antibiotics** (IV) as per local guidelines ☐
2. **Cultures** (Blood and relevant) ☐
3. **Oxygen** to achieve Sats >94%& ≤ 98% ☐
4. **Fluid** (IV) (500ml / hour or 20ml/kg stat if organ dysfunction present) ☐
5. **Lactate** ☐
6. **Monitor urine output** (Catheterise if organ dysfunction apparent) ☐

No obvious source? Check throat, ears, joints, pressure sores, IV cannula/central line sites, remove dressings, consider endocarditis or foreign body (e.g. tampon). Consider possible non-infective cause (e.g. pancreatitis, transfusion reaction, trauma and burns).

If Severe Sepsis suspected (Lactate ≥ 4mmoll^{-1}) contact senior medic on-call /ERT/H@N, consider transfer to Medical HDU, Medical High Care or ITU referral. Septic patients require regular review by senior medic on-call /ERT/H@N; patient must be handed over accordingly.

Relevant Investigations

ECG: NSR 105bpm ischaemia

QTc 464 ms

CXR:

Urinalysis:

Leucocytes:
Nitrites:
Protein:
Blood:
Glucose:
Ketones:

Relevant Bloods:

U+Es (N)

LFTs AST 80
ALT 79
ALP 77
Bili 7
Alb 46

WCC 15.6
Hb 131
plts 201

CRP <5

ABGs:

Coag (N)

Bone (N)

ACUTE MEDICINE

Adult Medical Assessment Venous Thrombo-embolism (VTE) Prophylaxis Tool

[ADTC 213/2]

Do Not Use in Acute Stroke

Risks for thromboembolism (tick if apply)

- ☑ Age >60 years
- ☐ Active cancer or cancer treatment
- ☐ Any significant medical illness
  (e.g. cardiac, metabolic, endocrine, or respiratory disease, acute infection, inflammatory condition)
- ☐ Critical care admission e.g. HDU/ITU
- ☑ Dehydration
- ☐ Known thrombophilia
- ☐ Obesity (BMI > 30)
- ☐ Personal history or first degree relative with a history of VTE
- ☐ Pregnancy or < 6 weeks post-partum
- ☐ Significantly reduced mobility for 3 days or more
- ☐ Use of hormone replacement therapy
- ☐ Use of oestrogen-containing contraceptive therapy

→ **No Risk Factors** ☐

→ **No prophylaxis required**
- Review decision 3x weekly

↓ **1 or more Risk Factors**

Contraindications to Dalteparin (tick if apply)

- ☐ **Lumbar Puncture**/Epidural/Spinal Anaesthesia in previous 4 hours *or expected within next 12 hours*
- ☐ Any other procedure with high bleeding risk expected during this admission (including neurosurgery, spinal or eye surgery)
- ☐ Active bleeding
- ☐ Acute stroke
- ☐ Acute gastro-duodenal ulcer
- ☐ Acquired bleeding disorders e.g. acute liver disease
- ☐ Previous Heparin Induced Thrombocytopaenia (HIT)
- ☐ Thrombocytopaenia (Platelets $<75x10^9/L$)
- ☐ Concurrent use of **any** other anticoagulants (e.g. Warfarin)
- ☐ Uncontrolled hypertension >230/120 mmHg
- ☐ Untreated inherited bleeding disorders
- ☐ Any other concern (document in case notes)

→ **Any Contraindications** ☐

→ **Do not prescribe LMWH**
- Consider Anti Embolic stockings.
- Review decision 3x weekly

↓ **No Contraindications** ☑

Please prescribe Dalteparin 5000 units subcutaneously once daily ☑

- FBC (platelets) to be checked on day 0 and day 1.
- Review VTE prophylaxis 3x weekly

NB. reduction of prophylactic dose NOT required for patients with renal impairment (eGFR <30 ml/min)

Discussion with patient regarding risk of VTE & risks/benefits of LMWH ☑

☐ **Acute Coronary Syndrome** should receive treatment dose Dalteparin

☐ **Suspected DVT or Pulmonary Embolism** should receive treatment dose Dalteparin, until excluded.

NB. treatment dose LMWH should be reduced by 20% if eGFR <30 ml/min – see ADTC 75

Write or attach label

CHI No .....

Surname: .....

Forename: ..... Sex: .....

DOB: .....

Impression • Differential Diagnosis • Problem List

1) Probable alcoholic gastritis

2) Alcohol withdrawal

Management Plan

All investigations listed must be annotated in a way that makes it clear if suggested, requested or performed.
Example: *"CT- requested on PMS* ☑"; "*Urinalysis – awaited* ☐"

1) Peptac

2) Pabrinex 1+11 x 2

3) GMANS PRN

ACUTE MEDICINE

All Patients	
Blood results reviewed and printed:	☑
VTE prophylaxis assessed:	☑
Investigations requested:	☑
In-patient prescription chart complete:	☑
Considerations	
Sepsis 6?	☐
Adults With Incapacity?	☐
DNA-CPR?	☐
HIV test?	☐

Dr Jonathan Donald
ST.... Emergency Medicine
GMC no. 7485639
Page no. .....

Name & grade (ID stamp):

Signature:

Page: 3229

Ward: CAU

Date: 04/11/18

Time: 1300

Pneumonia

CURB65 Score

C	Confusion (4 point AMT ≤ 3)	1
U	Urea >7 mmol/L	1
R	Respiratory Rate >30/min	1
B	Systolic BP <90 mmHg	1
65	Age greater than 65	1

Score 0 - 1 = Mild = PO Abx
Score 2 = Moderate = IV Abx
Score ≥ 3 = Severe = IV Abx

Always refer to local antibiotic policy

Use clinical judgement (e.g. bilateral pneumonia, degree of hypoxia).

Upper GI Bleed

Glasgow Blatchford Score

Criterion	Male	Female	Score
Hb (g/dL)	120-130	100-120	1
	100-120	-	3
	<100	<100	6
Urea (mmol/L)	6.5 - 8		2
	8 - 10		3
	10 - 25		4
	>25		6
Systolic BP	100 - 109		1
	90 - 99		2
	< 90		3
Pulse ≥ 100	Present		1
Melaena	Present		1
Syncope	Present		2
Liver	Present		2
CCF	Present		2

Score 0 – 1; consider early discharge
Score >6 = 50% likely need intervention

TIA Assessment

$ABCD_2$ Score

Age > 60	1
BP >140 / 90	1
Speech disturbance	1
Unilateral weakness	2
Duration 10-59 min	1
≥ 60 min	2
Diabetes	1

Score <4; start aspirin 300mg.

Score ≥4; start aspirin 300mg & specialist assessment <24h; carotid doppler / brain imaging.

Pulmonary Embolism

Simplified Geneva score

Age >65 years	1
Previous DVT or PTE	1
Surgery or fracture in last month	1
Active malignancy (or cure <1yr)	1
Unilateral lower limb pain	1
Haemoptysis	1
Heart rate 75 to 94 bpm	1
Heart rate >94 bpm	+1

Score ≤ 2 → for D-Dimer
Score > 2 → not for D-dimer, for appropriate imaging eg V̇/Q̇ or CTPA

Alcoholic Hepatitis

Glasgow Alcoholic Hepatitis

Age	< 50	1
	≥ 50	2
WCC	< 15	1
	≥ 15	2
Urea	< 5	1
	≥ 5	2
INR	< 1.5	1
	1.5 - 2	2
	> 2	3
Bilirubin	< 125	1
	125 - 250	2
	> 250	3

If total > 9, consult Gastro about steroids

Maddrey's score

= (4.6 x (PT test - control)) + Bilirubin ÷17

(If total >32, consider steroids)

Oxygen Therapy

BTS Guidance

No risk of chronic hypercapnic respiratory failure:

Aim sats 94 – 98%
If sats < 85% initially use trauma mask 15L

Risk of chronic hypercapnic respiratory failure/COPD

Aim sats 88 – 92%
Initially use Venturi mask 28%

Deep Vein Thrombosis

Modified Wells

Active malignancy (or Rx ≤ 6mo)	1
Paralysis or plaster	1
Bedridden >3/7	1
Vein tenderness	1
Entire swollen leg	1
Difference in calf >3cm	1
Unilateral oedema	1
Previous DVT	1
More likely diagnosis	-2

Score < 2, low risk, for D-dimer
Score ≥ 2, high risk, for Doppler ultrasound

Acute Pancreatitis

Imrie Severity Score

PaO_2 < 7.9 kPa	1
Age > 55	1
WCC >15 x10^9/L	1
Calcium < 2 mmol/L	1
Urea >16 mmol/L	1
LHD > 600 IU or AST > 200 IU	1
Albumin < 32 g/L	1
Glucose > 10 mmol/L	1

If considering pancreatitis, request surgical review

If the score ≥ 3, severe pancreatitis likely: contact surgeons & consider Surgical HDU / ITU

Anion Gap

= $(Na^+ + K^+) – (Cl^- – HCO_3^-)$

Used to assess the contribution of unmeasured anions to acidosis. Normal range 10-20 mmol/L.

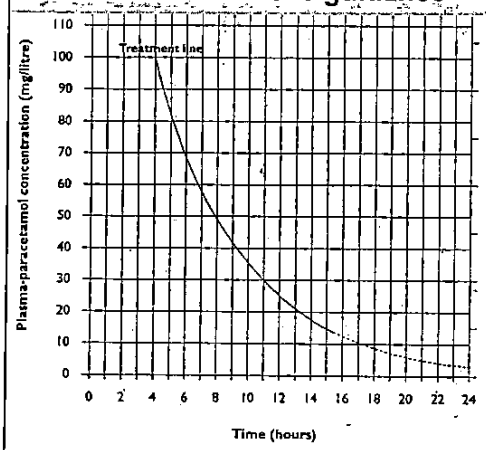
Non-Valvular AF anticoagulation

CHA_2DS_2 Vasc

Heart Failure	1
Hypertension	1
Age 65 - 74	1
Age ≥ 75	2
Diabetes	1
Previous TIA or stroke	2
Vascular disease	1
Female	1

If ≥1, for Warfarin
Consider LMWH & novel oral anti-coagulants.

Paracetamol Overdose guidance



Where level is above treatment line, give N-acetylcysteine (Parvolex)

Treatment with N-AC: (1) ascertain patient's weight and (2) use adult dosage table to determine the appropriate volume of N-AC to be added to the infusion fluid for each of the 3 infusion periods.

For full information refer to Toxbase & BNF:
Emergency treatment of poisoning > Specific drugs > Paracetamol.

Therapeutic excess:

Give N-AC if jaundice, hepatic tenderness, or ingested >150mg/kg in 24hrs.

Consider N-AC if ingested 75-150mg/kg in 24 hrs if glutathione deplete (eg. chronic debilitating illness, malnourished patients, ie. not eaten for a few days, eating disorders, cystic fibrosis, AIDS, cachexia, alcoholism, cirrhosis)

Write or attach label

CHI No .....

Surname: .....

Forename: ..... Sex: .....

DOB: .....

Consultant Opinion Date: 5/11/18 Time: 1025 Ward: CAU (AMC)

53 ↗ • Alcohol withdrawal

— Lower crampy abdo pain.

— Stopped drinking alcohol — now withdrawing.

— Somewhat constipated.

ECG: Sinus.

~~CXR:~~

Blds: WCC 15.6.
Hb 131 (136)
AST 80
ALT 79
CRP <5.

O/E: BP 190/

Clear HS pure

SNT. Calves SNT

Imp/ Alcohol withdrawal. Constipation.

Plan/ Pabrinex.
GMANS.
Alc. liaison
Laxatives.
GMANS assessment → ? regular benzos.
Monitor BP.

Blds tomorrow → ? LFTs settling

Discharge / Allocate: GEN

EDD: <24hr (24-72 hrs) >72 hrs

Name (ID Stamp):

Signature: SMITH

Clinical Governance

Medicine Reconciliation complete	☐
VTE Prophylaxis Assessed & prescribed	☐
Antibiotics as per microbiology policy	☐
DNA-CPR status considered	☐
Escalation of care/ceiling of treatment considered	☐

ACUTE MEDICINE

Continuation

5/11/18 - 12:00/ANP C.HASTIE.

. Requires Regular + PRN GMANS as per Guidelines
Please monitor for over sedation

Colin Hastie
Advanced Nurse Practitioner
NMC: 03109465 Page: 3129

6/11/18 MIDLOTHIAN - CDF D2 CAV R&V
1050

53 6↗ · alcohol withdrawal

Pt reports feeling dizzy on standing since taking diazepam.
Otherwise feeling well
Abdo pain settled
Bowels opened this morning.

HR ~100
Other obs (A).

MS 1+11+0

SNT
BSV

Neuro (N).

(P) ↓ dose diazepam 15mg QDS
Continue GMANS/Pabrinex.

ROSSM
#3054

Write or attach label

CHI No .....

Surname: .....

Forename: ..... Sex: .....

DOB: .....

Continuation

7/11/18 A. Al-Dallaali SD

0943

WR XAA

- History noted
- Patient refused to take diazepam occasionally as it makes him dizzy
- Not Storing today
- Abdominal Pain and diarrhoea settled

- AST 80 → 171
  ALT 79 → 201

- Plan: Alcohol Liaison Review
  - Update Hourly

Dr Abdullah Al-Dallaali
Clinical Teaching Fellow
GMC 7222427 Page No.....

* AST 162
  ALT 223

ACUTE MEDICINE

Continuation

- Liver screen
- Outpatient ultrasound Abdomen
- To return 9/11/18 to RAA for repeat LFT
- Alcohol liaison will contact him later today
- Discharge with worsening advice

Dr Abdullah Al-Dallaali
Clinical ...
GMC 7222427 Page No. ...

9/11/18 A. Al-Dallaali SD

Patient returned for repeat LFT.

Bil <3
AST 107
ALT 210

Liver screen: Ferritin 376.3, ESR 17
IgM

D/W Dr Shah, for outpatient ultrasound and to refer him to the gastro clinic

Dr Abdullah Al-Dallaali
...
GMC 7222427 Page No. ...

Patient Information			
STEPHEN GALLOWAY		Date:	13/08/2018
		Incident Number:	CR004856642
Age/Gender:	53 years 1 months 30 days Old Male		
Address:	28 REDBURN PLACE IRVINE,KA12 9DH	Incident Type:	URG
DOB:	14/06/1965	Incident Location:	DR MCSHERRY & PARTNERS FREW TERRACE SURGERY,9 FREW TERRACE IRVINE, KA12 9DY
CHI:	0406650854		
Ethnicity:			

Scottish Ambulance Service

Presenting Complaint

INCREASED ALCOHOL INTAKE 4/7

Additional Comments

GP REF FOR 53YOM FOLLOWING INCREASED ALCOHOL INTAKE OVER PREVIOUS 4/7. O/A PT SITTING IN SURGERY WAITING ROOM, FULLY ALERT AND ORIENTATED. O/E PT TAQHYCARDIC, HYPERTENSIVE, OTHER OBS WITHIN EXPECTED PARAMETERS. PT GIVEN 2X TABLETS BY GP PRIOR TO CREW ARRIVAL, BELIEVED TO POSSIBLY BE DIAZEPAM.

PATIENT ASSESSMENT

AVPU	Alert		<C>	No
A	Clear			
B				
C	Pulse Rate	BP	Cap Refill	ECG Rhythm
	120	175/104	<=2 Secs	
	Rhythm	Arm	Central/Peripheral	ECG
	Reg	Left	Peripheral	
D	GCS	Eyes	Voice	Motor / PEARL
	15	Spontaneously (4)	Orientated (5)	Obeys Commands (6) / Yes
E				

Observations

Time	P	RR	BP	SpO2	CR	GCS	AVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
11:55	118	16	168/98	97	<=2s	15	Alert								E9888689
11:45	120	16	175/104	96	<=2 Secs	15	Alert		37.5	5.4					E9888689

NEWS

Time	Clinical Risk	NEWS
11:55	LOW Immediate Clinical Risk. Treat as per Clinical Practice Guidelines including considering the use of alternative pathways (if appropriate and available).	2
11:45	LOW Immediate Clinical Risk. Treat as per Clinical Practice Guidelines including considering the use of alternative pathways (if appropriate and available).	2

HISTORY

AMPLE

Allergies	None
Medication	OMEPRAZOLE
Past Medical History	Hypertension
Last Eaten	>4 Hours Ago
Events Prior	INCREASED ALCOHOL INTAKE

Social History

Lives alone	Yes	Patient Occupation	Does Not Work
Patients General Appearance	Normal		
Patient Mobility	Fully Mobile		

Patient Communication	No Help Required
Patient Clinical Risk Factors	Alcohol, Smoker

CLOSE RECORD

Treatment On Scene	Non Emergency

Conveyance

Transport To Hospital	Normal driving	Pre Alert	No

INCIDENT LOG

Time Call Received	11:20	Allocated	11:24	Mobile	11:26
First Resource On Scene		Crew On Scene	11:41	Crew Left Scene	11:48
Crew At Hosp		Receiving Hospital	CROSSHOUSE HOSPITAL	Clear Time	

Crew ID	Crew Grade	Driver
E1023292	Ambulance Technician	YES
E9888689	Paramedic	NO

NHS Ayrshire & Arran

CAU Referral Information

Date: 13/8/18 Time call taken: 1119.

Name call handler: lynne.

53

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

Referral source:

ED to: Acute Med/ED Ambulatory pathway ED Time of arrival:

GP Letter with patient/mailbox/fax from Home/NH

Other please state: Ambulance Y/N

CLINICAL ALERT PRESENT

RED FLAG

Reason for referral:

alcohol wdl

alcks

DTs.

24ma spirits daily stopped 24hs ago.

Shaky.

Falls.

Observations NEWS= or [RR SpO2 Sup' O2 Temp HR 129 BP AVPU]

Delirium Y/N Planned destination:

Specific actions required on arrival:

Time of arrival IAA: 1220 **NEWS=** 2. **Immediate review required Y/N** **THINK SEPSIS 6**

4AT= **Frail** (as per screening tool) **Y/N** **Mental Health Risk Assessment** (if required)=

Comments: ? alcohol withdrawal. tremors.

clo generused pen.

Time referral to stroke team (if applicable):

Does patient have conditions that require medications pending medical review? Y/N

(Myasthenia Gravis Parkinson's disease Insulin dependent diabetes Seizures Steroid dependency/Addisons)

Review clinical alert printouts if present

Next of Kin: Power of Attorney:

Patient suitable for red dot chairs Y/N Name of assessor..... Time.1220.

PVC – think **DRIFT** (Diagnostics, Resuscitation, IV medication, Fluids, Transfusion) YES.

	Required	Performed		Required	Performed
U&Es	✓		ABG		
FBC	✓		LFTs	✓	
Glucose	✓		TnT		
Coag	✓		ECG	✓	
Lactate			CXR		
CRP	✓		Urine	✓	
VBG			Other tests Bone.	✓	
Blood Cultures					

A80698 Frew Terrace Surgery 13 08 2018
Phone 01294 272326

Referral to Hospital

Specialty **CAU**
Referring GP **Dr N Begg**

Patient
Stephen Galloway (Phone no: 07468 337186)

28 Redburn Place
Irvine
KA12 9BH

Age 53 years
CHI 1406650854

Problem

Dear Colleague,

Many thanks for seeing this 53 year old gentleman.

Please find below my recent assessment and comments.

Yours sincerely

Consultations - Last 10

	13/08/2018 11:31, Main Surgery, Mrs Mairi McKelvie
Comment	1 hr ambulance ordered - ref 4856642 to attend Frew Terrace Surgery
	13/08/2018 11:00, Main Surgery, Dr Nicola Begg
(First) Problem	Alcohol dependence syndrome
History	See triage. ETOH dependence. Drinking 2L spirits per day. stopped 24 hrs ago. onset of withdrawal symptoms 3am. shaky. tingly hands.

	swollen hands. feeling generally terrible and sore. pain L flank and L lower chest / upper abdo. aware of this when walking around but difficult to get clear history as distressed at the moment. no vomiting. chronic diarrhoea. not been eating much. lives alone. doesn't drive. had DTs in the past. c/o blurry vision (not new) but also ??seeing something out corenrs of eyes - not able to clearly explain. no other hallucinations at present. multiple falls and head injuries recently. also hurt R shoulder in recent fall. no h/o etoh-related seizures.
Examination	General examination of patient
	Systolic blood pressure, 180 mm Hg
	Diastolic blood pressure, 76 mm Hg
	O/E - pulse rate, 129 beats/minute
	O/E - tympanic temperature, 37.3 C
	orientated to time/place/person. tremulous. agitated. HS pure. chest clear. tender across upper abdo but abod soft. no heaptomegaly. PERL. FROEM. nystagmus . reports diplopia in all directions of gaze. no facial weakness/sensory loss. tone increased. power OK all 4 limbs (excpet RUL as limited by shoudler pain). coordination OK.
Comment	Imp: acute ETOH withdrawal. keen for admission / to complete detox. Plan: admit CAU XH. d/w receiving nurse - accepted. 20mg diazepam to be given whilst awaiting 1 hr ambulance. chest pain / shoulder pain / abdo pain can be further assessed at hospital once withdrawal Sx treated. will need pabrinex too.
Result	Oxygen saturation at periphery, 96 %
Medication	Diazepam Tablets 10 mg 2 tablet 20MG AS SINGLE DOSE
	13/08/2018 09:44, Telephone Consultation, Dr Thomas Miller
History	Triage. D/W patient. Long hx of alcohol problems. Excess alcohol in his 20s and 30s; underwent inpatient detox in Dykebar 15y ago. Abstinent for ~12y but now 2y hx of almost daily alcohol. Consuming 1-2 litres gin per day. No alcohol since yesterday moring; now feels shaky. Requests input re alcohol. Appt given for assessment and likely referral.
	13/08/2018 08:32, Telephone Consultation, Dr Thomas Miller
History	Triage. Telephoned mobile at 8.32; no answer.; message left.
	26/06/2018 09:43, Main Surgery, Dr Duncan McNab
(First) Problem	Medically unexplained symptoms
History	chronic headache neck pain and describes episodes where falls asleep - unsteady when tries to climb ladder and has fallen off on one occasion. all started 2 years ago after getting run down. painter and decorator. has had full investigation and see neurology states MUS. discussed this with stephen today and accets no structural cause. explored psychological contributroy factors sleep por dies worru re kids and ex. but does not seem depressed or pa=rticularly anxious.

Comment	discussed reyrurn to work but the symptoms he describes would make painter and decorator not safe. he will get medical soon and have to look for any work. aware of this. note what I have written on line he agrees with this.
Additional	FitNote.pdf, eMED3 (2010) new statement issued, not fit for work (Diagnosis: ongoing unexplained headache and neck pain - no obvious cause on scanning; Duration: 07/06/2018 - 06/08/2018)
	26/06/2018 08:50, Telephone Consultation, Mrs Margaret Milligan
History	Triage - looking for further fit note - documented on 2/5/18 not for further, thought it was for 2 months, unable to come to Lfw for review with Dr Miller appt at Ft released.
	02/05/2018 17:48, Main Surgery, Dr Thomas Miller
History	Attended for review as requested by surgery re fitnotes. HAs received med certs since Aug 16 following cervical nerve compressions. Has had x2 CT brain, MRI neck and brachial plexus, nerve conduction studies and neurology appts; all investigations normla. Gets occassional headaches and neck pain but nil else. No analgesia.
Examination	Systolic blood pressure, 132 mm Hg
	Diastolic blood pressure, 76 mm Hg
	Freely ,mobile. Bright and chatty. No neck pain. Nil else of note.
Social	Painter and decorator
Comment	Advised needs to return to Jobseekers and try to get back into employment. Agreed to further line for 1 mth but none thereafter.
Additional	FitNote.pdf, eMED3 (2010) new statement issued, not fit for work (Diagnosis: Headaches and Neck Pain; Duration: 02/05/2018 - 04/06/2018)
	23/04/2018, Main Surgery, Mrs Christina Young
Examination	O/E - blood pressure reading
	Systolic blood pressure, 138 mm Hg
	Diastolic blood pressure, 76 mm Hg
Comment	BP improved
	17/04/2018 10:00, Special Request, Dr Catriona McHugh
History	dealt with as triage. attended front desk but no phone- coming back for fit note. fit note issued but also appt for review on 2/5/18 to assess and also follow up from FH appt. needs BP appt also booked prior to this. staff at front desk advised and note attached
Additional	FitNote.pdf, eMED3 (2010) new statement issued, not fit for work (Diagnosis: cervical nerve root compression; Duration: 17/04/2018 - 02/05/2018)
	14/03/2018, Special Request, Dr Catriona McHugh

History	long term fit note- suggest review for next one with usual GP
Additional	FitNote.pdf, eMED3 (2010) new statement issued, not fit for work (Diagnosis: cervical nerve root compression; Duration: 14/03/2018 - 11/04/2018)

Problem - All

	Details
Active	
02/02/2017	EMG - Electromyography normal
02/02/2017	Nerve conduction studies
04/04/2014	Erectile dysfunction

Current Repeat Prescriptions

Medication - All

	Details	Dosage/Quantity
Current Repeat		
25/07/2018P	Lansoprazole Capsules (Gastro-Resistant) 30 mg	ONE TO BE TAKEN EACH DAY, 56 capsule
07/08/2018P	Tadalafil Tablets 5 mg	TO BE TAKEN AS DIRECTED, 8 TABLET

Recent Acute Prescriptions (last 3 months)

Medication - From 3M Ago To Present

	Details	Dosage/Quantity
Current Acute		
13/08/2018P	Diazepam Tablets 10 mg	20MG AS SINGLE DOSE, 2 tablet

Medication - From 3M Ago To Present

	Details	Dosage/Quantity

NHS Ayrshire & Arran

Acute Medicine Assessment Proforma

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

Date: 13·8·18	Time: 12:20
Referral source: GP	Receiving Consultant: Dr Smith

Presenting Complaint

53 ♂

Presented to GP asking for help to stop drinking alcohol.

- Last alcoholic drink 11am 12·8·18.

States reason is multiple recent falls while intoxicated.

Patient woke at 3am feeling very shaky, sweaty, anxious, and distressed: similar to previous DTs. Some general muscle aches + pains.

otherwise well - no recent infections
chronic diarrhoea.

- 1L spirits per day
= 210 units per week.

Past Medical History

ACUTE MEDICINE

Multidisciplinary Medicines Reconciliation

Must be started by admitting Clinician within 24 hours

Source of information (use at least two sources) (Tick)

Patient	☐	Emergency Care Summary	☐
Relative / Carer	☐	Nursing Home Chart	☐
Patient's Own Drugs	☐	Previous Discharge Letter	☐
GP Referral Letter	☐	Repeat Prescription	☐
GP Practice	☐	Other (please specify)	☐

Admission Medicines			Action Note: Unless otherwise indicated below, medicines should be continued on prescription sheet				
Name, Form, Route (spec. if not oral)	Dose	Frequency e.g. 3X	Suspend	Amend	Stop	Comments (if medicine suspended, amended stopped or inaccurate)	Pharm initials if change

OTC / Herbal / Homeopathic / Illicit substances	Further information e.g. compliance aid, recent discontinued medicines

Adverse Reactions / Allergies Non known ☐ or

Medicines / Substance	Reaction

Are you satisfied this medication history is complete and accurate? YES ☐ NO ☐

If NO what further action is necessary (Contact GP etc) ..... Tick when resolved ☐

Pharmacist review signature ..... Date/Time ..... Beep No .....
(Initial changes / additions above)

ACUTE MEDICINE

Write or attach label

CHI No .....

Surname: .....

Forename: ..... Sex: .....

DOB: .....

Family History

Social History (As relevant)

Works as:

Lives with: Alone

Mobilises using:

Home Care: (I)

Family Support:

Recent Travel: No

Functional Capacity:
(eg. climb a flight of stairs?)

Alcohol (units/wk): XS

Smoker (Yes) No / Ex ← ~12 roll ups per day.

Systematic Enquiry (As relevant)

Weight loss / Appetite

Cardiovascular

Respiratory

Gastrointestinal

Urinary

Neurological

Musculoskeletal

ENT / Eyes

Skin

Endocrine

Gynaecology

Mental Health

Physical Activity screening:

Does the patient undertake 30 minutes of moderate physical activity 5 days per week?

Yes ☐ No ☐ If no, consider referral to local council physical activity advice program

Looks reasonably well.

General Examination

Temp: 36.6°C Pulse: 110 RR: 18

SpO_2: 96 % FiO_2: Air (mask/NP)

BP - Lying: 195 / 100

Standing$_{(1min)}$: /

Calves:

Delirium and Cognitive Assessment

4AT score _____ Use if over 65 or confused

Nursing staff will do this on admission; transcribe from their admission document.

The 4AT score helps distinguish delirium from cognitive impairment. Delirium is more likely in the acute setting.

Score ≥ 4: delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: unlikely delirium or cognitive impairment

If ≥4 then commence Delirium Pathway

Cardiovascular Examination

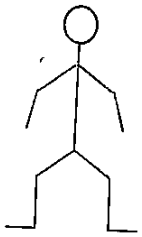
HS: I ___ II ___ +0 ~~murmur~~

Heaves / Thrills

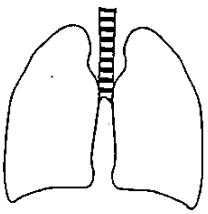
Pulses:

JVP:

Oedema: Nil



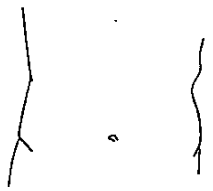
Respiratory Examination



clear
Good AE

Peak flow:

Abdominal Examination



~~liver flap~~

Soft

Bowel sounds:

PR:

General Neurological Examination

GCS: 15 /15 (E___/4, M___/6, V___/5)

Gait? Tremor? Meningism?

~~very~~ Shaky

Peripheral and Cranial Nerve Examination

	RUL	LUL	RLL	LLL
Pronator drift			-	-
Tone				
Power				
Reflexes				
Sensation				
Co-ordination				
Plantar reflexes				

Write or attach label

CHI No .....

Surname: .....

Forename: ..... Sex: .....

DOB: .....

Improving Sepsis Survival: Use if infection suspected *and* SIRS ≥ 2 or MEWS ≥ 4

Systemic Inflammatory Response Syndrome

- Temp >38° or < 36° ☐
- White cell count >12 or < 4 ☐
- Heart rate >90 min^{-1} ☐
- Respiratory rate > 20 min^{-1} ☐
- Acutely altered mental state: (4-Point AMT ≤ 3) ☐
- Bedside glucose >7.7 $mmoll^{-1}$ (without Diabetes) ☐

Sepsis Six

Must be complete within 1 hour suspected sepsis or SIRS criteria met.

1. **Antibiotics** (IV) as per local guidelines ☐
2. **Cultures** (Blood and relevant) ☐
3. **Oxygen** to achieve Sats >94%& ≤ 98% ☐
4. **Fluid** (IV) (500ml / hour or 20ml/kg stat if organ dysfunction present) ☐
5. **Lactate** ☐
6. **Monitor urine output** (Catheterise if organ dysfunction apparent) ☐

No obvious source? Check throat, ears, joints, pressure sores, IV cannula/central line sites, remove dressings, consider endocarditis or foreign body (e.g. tampon). Consider possible non-infective cause (e.g. pancreatitis, transfusion reaction, trauma and burns).

If Severe Sepsis suspected (Lactate ≥ 4mmoll^{-1}) contact senior medic on-call /ERT/H@N, consider transfer to Medical HDU, Medical High Care or ITU referral. Septic patients require regular review by senior medic on-call /ERT/H@N; patient must be handed over accordingly.

Relevant Investigations

ECG:

SR QTc 460

CXR:

Urinalysis:

Leucocytes:
Nitrites:
Protein:
Blood:
Glucose:
Ketones:

Relevant Bloods:

ABGs:

ACUTE MEDICINE

Adult Medical Assessment Venous Thrombo-embolism (VTE) Prophylaxis Tool

Do Not Use in Acute Stroke

[ADTC 213/2]

Risks for thromboembolism (tick if apply)

- ❑ Age >60 years
- ❑ Active cancer or cancer treatment
- ❑ Any significant medical illness
  (e.g. cardiac, metabolic, endocrine, or respiratory disease; acute infection; inflammatory condition)
- ❑ Critical care admission e.g. HDU/ITU
- ❑ Dehydration
- ❑ Known thrombophilia
- ❑ Obesity (BMI > 30)
- ❑ Personal history or first degree relative with a history of VTE
- ❑ Pregnancy or < 6 weeks post-partum
- ❑ Significantly reduced mobility for 3 days or more
- ❑ Use of hormone replacement therapy
- ❑ Use of oestrogen-containing contraceptive therapy

→ **No Risk Factors** ❑

→ **No prophylaxis required**
- Review decision 3x weekly

↓ **1 or more Risk Factors**

Contraindications to Dalteparin (tick if apply)

- ❑ **Lumbar Puncture**/Epidural/Spinal Anaesthesia in previous 4 hours *or expected within next 12 hours*
- ❑ Any other procedure with high bleeding risk expected during this admission (including neurosurgery, spinal or eye surgery)
- ❑ Active bleeding
- ❑ Acute stroke
- ❑ Acute gastro-duodenal ulcer
- ❑ Acquired bleeding disorders e.g. acute liver disease
- ❑ Previous Heparin Induced Thrombocytopaenia (HIT)
- ❑ Thrombocytopaenia (Platelets $\leq 75 \times 10^9$/L)
- ❑ Concurrent use of **any** other anticoagulants (e.g. Warfarin)
- ❑ Uncontrolled hypertension ≥230/120 mmHg
- ❑ Untreated inherited bleeding disorders
- ❑ Any other concern (document in case notes)

→ **Any Contraindications** ❑

→ **Do not prescribe LMWH**
- Consider Anti Embolic stockings.
- Review decision 3x weekly

↓ **No Contraindications** ❑

Please prescribe Dalteparin 5000 units subcutaneously once daily ❑

- FBC (platelets) to be checked on day 0 and day 1.
- Review VTE prophylaxis 3x weekly

NB. reduction of prophylactic dose NOT required for patients with renal impairment (eGFR <30 ml/min)

Discussion with patient regarding risk of VTE & risks/benefits of LMWH ❑

❑ **Acute Coronary Syndrome** should receive treatment dose Dalteparin

❑ **Suspected DVT or Pulmonary Embolism** should receive treatment dose Dalteparin, until excluded.

NB. treatment dose LMWH should be reduced by 20% if eGFR <30 ml/min – see ADTC 75

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

Impression • Differential Diagnosis • Problem List

Acute alcohol withdrawal

QTc 460.

Management Plan

Investigations listed must be annotated in a way that makes it clear if suggested, requested or performed.
Example: *"CT- requested on PMS* ☑"; *"Urinalysis – awaited* ☐"

Pabrinex ✓
GMAWS - regular + PRN ✓
Usual meds ✓
Monitor bowels – if liquid, send for culture.
Addictions team.

ACUTE MEDICINE

All Patients

Blood results reviewed and printed:	☐
VTE prophylaxis assessed:	☐
Investigations requested:	☐
In-patient prescription chart complete:	☐

Considerations

Sepsis 6?	☐
Adults With Incapacity?	☐
DNA-CPR?	☐
HIV test?	☐

Name & grade (ID stamp): Dr Emily Dirks, LAS in Acute Medicine, GMC 7451951 Page No.....
Signature: EDIRKS.
Page: 342/
Ward: 1A
Date: 13.8.18.
Time: 1238

Pneumonia

CURB65 Score

C	Confusion (4 point AMT ≤ 3)	1
U	Urea >7 mmol/L	1
R	Respiratory Rate >30/min	1
B	Systolic BP <90 mmHg	1
65	Age greater than 65	1

Score 0 - 1 = Mild = PO Abx
Score 2 = Moderate = IV Abx
Score ≥ 3 = Severe = IV Abx

Always refer to local antibiotic policy

Use clinical judgement (e.g. bilateral pneumonia, degree of hypoxia).

Pulmonary Embolism

Simplified Geneva score

Age >65 years	1
Previous DVT or PTE	1
Surgery or fracture in last month	1
Active malignancy (or cure <1yr)	1
Unilateral lower limb pain	1
Haemoptysis	1
Heart rate 75 to 94 bpm	1
Heart rate >94 bpm	+1

Score ≤ 2 → for D-Dimer
Score > 2 → not for D-dimer, for appropriate imaging eg V/Q or CTPA

Deep Vein Thrombosis

Modified Wells

Active malignancy (or Rx ≤ 6mo)	1
Paralysis or plaster	1
Bedridden >3/7	1
Vein tenderness	1
Entire swollen leg	1
Difference in calf >3cm	1
Unilateral oedema	1
Previous DVT	1
More likely diagnosis	-2

Score < 2, low risk, for D-dimer
Score ≥ 2, high risk, for Doppler ultrasound

Upper GI Bleed

Glasgow Blatchford Score

Criterion	Male	Female	Score
Hb (g/dL)	120-130	100-120	1
	100-120	-	3
	<100	<100	6
Urea (mmol/L)	6.5 - 8		2
	8 - 10		3
	10 - 25		4
	>25		6
Systolic BP	100 - 109		1
	90 - 99		2
	< 90		3
Pulse ≥ 100	Present		1
Melaena	Present		1
Syncope	Present		2
Liver	Present		2
CCF	Present		2

Score 0 – 1; consider early discharge
Score >6 = 50% likely need intervention

Alcoholic Hepatitis

Glasgow Alcoholic Hepatitis

Age	< 50	1
	≥ 50	2
WCC	< 15	1
	≥ 15	2
Urea	< 5	1
	≥ 5	2
INR	< 1.5	1
	1.5 - 2	2
	> 2	3
Bilirubin	< 125	1
	125 - 250	2
	> 250	3

If total > 9, consult Gastro about steroids

Maddrey's score

= (4.6 x (PT test - control)) + Bilirubin ÷17
(If total >32, consider steroids)

Acute Pancreatitis

Imrie Severity Score

PaO_2 < 7.9 kPa	1
Age > 55	1
WCC >15 x10^9/L	1
Calcium < 2 mmol/L	1
Urea >16 mmol/L	1
LHD > 600 IU or AST > 200 IU	1
Albumin < 32 g/L	1
Glucose > 10 mmol/L	1

If considering pancreatitis, request surgical review

If the score ≥ 3, severe pancreatitis likely: contact surgeons & consider Surgical HDU / ITU

Anion Gap

= $(Na^+ + K^+) - (Cl^- - HCO_3^-)$

Used to assess the contribution of unmeasured anions to acidosis. Normal range 10-20 mmol/L.

TIA Assessment

$ABCD_2$ Score

Age > 60	1
BP >140 / 90	1
Speech disturbance	1
Unilateral weakness	2
Duration 10-59 min	1
≥ 60 min	2
Diabetes	1

Score <4; start aspirin 300mg.
Score ≥4; start aspirin 300mg & specialist assessment <24h; carotid doppler / brain imaging.

Oxygen Therapy

BTS Guidance

No risk of chronic hypercapnic respiratory failure:
Aim sats 94 – 98%
If sats < 85% initially use trauma mask 15L

Risk of chronic hypercapnic respiratory failure/COPD
Aim sats 88 – 92%
Initially use Venturi mask 28%

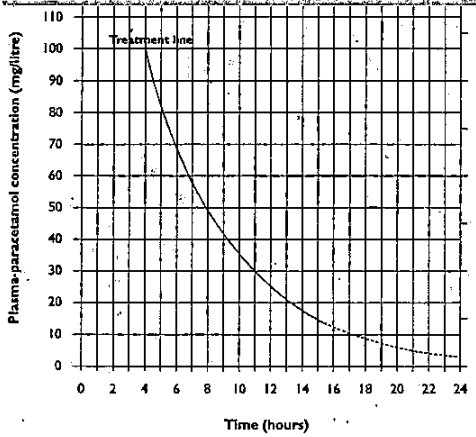
Non-Valvular AF anticoagulation

CHA_2DS_2 Vasc

Heart Failure	1
Hypertension	1
Age 65 - 74	1
Age ≥ 75	2
Diabetes	1
Previous TIA or stroke	2
Vascular disease	1
Female	1

If ≥1, for Warfarin
Consider LMWH & novel oral anti-coagulants.

Paracetamol Overdose guidance



Where level is above treatment line, give N-acetylcysteine (Parvolex)

Treatment with N-AC: (1) ascertain patient's weight and (2) use adult dosage table to determine the appropriate volume of N-AC to be added to the infusion fluid for each of the 3 infusion periods.

For full information refer to Toxbase & BNF:
Emergency treatment of poisoning > Specific drugs > Paracetamol.

Therapeutic excess:

Give N-AC if jaundice, hepatic tenderness, or ingested >150mg/kg in 24hrs.

Consider N-AC if ingested 75-150mg/kg in 24 hrs if glutathione deplete (eg. chronic debilitating illness, malnourished patients, ie. not eaten for a few days, eating disorders, cystic fibrosis, AIDS, cachexia, alcoholism, cirrhosis)

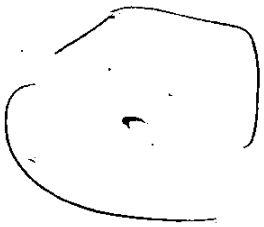
CHI: 1406650854
C Galloway, Stephen
28 Redburn Place
S Irvine
KA12 9BH
F 14/06/1965
Dr TG Miller
[MRN: XHI468158

Consultant Opinion Date: Time: Ward:

13/8/18. 17.40.

D T1

- setting



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-

15/8/18

ACUTE MEDICINE

Discharge / Allocate:

EDD: <24hr 24-72 hrs >72 hrs

Name (ID Stamp):

Signature:

Clinical Governance

Medicine Reconciliation complete	☐
VTE Prophylaxis Assessed & prescribed	☐
Antibiotics as per microbiology policy	☐
DNA-CPR status considered	☐
Escalation of care/ceiling of treatment considered	☐

Continuation

14/8/18 A.Taylor - CT3 ACCS CMU-N Day 2.
09:20

Issues: ① etoh withdrawal → GMAWS → Pabrinex

Obs: RR 15, SpO2 96% (A), T 36.5°C, Hr 80, 155/90
on regular diazepam 20mg → not scoring above.
currently having a shower.

(P) ↓ Diazepam to 15mg QDS to cont. detox
bloods mane

Dr Anna Taylor
Core Medical Trainee
GMC 7265227 Page 3529

15/8/18
09:24hrs. J. FABIYI GPST1 Day 3

Issues: Alcohol withdrawal
on GMAWS & Pabrinex.

NEWS = 0
RR 16, SpO2 98% RA, T: 36.6°C, P - 80, BP 160/90.

CVS HS, +HS, +Ø

clear
B added sounds.

SNT

no pedal edema.
Pt not shaky today.

Plan: ① ↓ Diazepam to 10mg QDS today 15/8/18
② ↓ Diazepam to 5mg QDS 16/8/18
③ ↓ Diazepam to 5mg BD 17/8/18.
④ Awaiting blood results.

Dr Joan Fabiyi
GP Specialty Trainee
GMC 7540424 Page

Write or attach label

CHI No .....

Surname: .....

Forename: ..... Sex: .....

DOB: .....

Continuation

16.08.18. WR. Dr. ALLEN.

Medically fit for discharge: no DTs.

ALCOHOL LIAISON review.

Discharge.

check HEP C. status (result to follow)

Dr. Sam Allen FRCP
Consultant
in Infectious Diseases
GMC 3563120 Page.....

ACUTE MEDICINE

Continuation

Nil allergies
Nil OTC

Patient Name	CHI	Date Of Birth	Age
Stephen Galloway	1406650854	14/06/1965	53

Source of Information

Patient	✓	Relative / Carer		Patient's Own Drugs		GP Letter		GP Practice	
Care home / MAR Chart		Previous Discharge Letter		Repeat Prescription Slip		Community Pharmacy		Other (Please State)	

Allergy Description	Date Recorded	Comments
NKDA		

Acute Medication (within 30 days)

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Continue	Withhold	Stop	Comments

Repeat Medication

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Continue	Withhold	Stop	Comments
	Tadalafil	5 mg Tablets	TO BE TAKEN AS DIRECTED		14-Jan-2014	07-Aug-2018		✓	✓		
	Lansoprazole	30 mg Capsules (Gastro-Resistant)	ONE TO BE TAKEN EACH DAY		21-Feb-2014	25-Jul-2018		✓			
	Nil else										

P Crosse
pharmacy
15/8/18 11.20

Patient Name	CHI	Date Of Birth	Age
Stephen Galloway	1406650854	14/06/1965	53

Repeat Medication

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Continue	Withhold	Stop	Comments

Compliance Device	Name and telephone number for community pharmacy

Completed by	Designation	Grade	Date	Time	Contact Number

Reviewed by	Designation	Grade	Date	Time	Contact Number

Write or attach label

CHI: 1406650854
Galloway, Stephen
66 Garnock Street
Dalry
KA24 4AW
14/06/1965
Dr ML Perman
MRN: A100750249

STA0238

DATE
18/7/17

Neurology
L shoulder mic: 14-15/cents
alc: occasional
pmh: HX: daughter → epilepsy
HX: anxiety / depression
Meds: ø

Sym: started 2 years ago
- sudden
- pain neck
- numbness of whole left side
→ ICH
MRI cerv. spine, plexus, MCC turned out to be normal
- leg numbness stopped after a day
- left wit LUL trapezius and rhomboid
- no weakness / clumsiness
- no change of sensory sym. → at LUL
Pic. Lam. Acne
- no new sx.

MEDICAL

DATE

- Pat. down the hall
  CC pain at the beginning
  2 mins ago
- CT head
- psych

OG

CROSSHOUSE HOSPITAL
EMERGENCY DEPARTMENT

dog b
Stc

NHS Ayrshire & Arran

A/E No: **XH-16-048324-1**

CHI No: **1406650854**

Date: **24 Aug 2016** Time: **12:12**

Consultant: **Tom Hopkins**

GALLOWAY

Stephen

GP
Dr. A AUGUSTINE
FREW TERRACE SURGERY
9 FREW TERRACE
IRVINE
AYRSHIRE
KA12 9DY

Incident Date: **24 Aug 2016**
Incident Time: **12:12**

Martial Status: **Single**

Date of Birth: **14 Jun 1965** Age: **51 Years**

Sex: **M**

Address:
28 REDBURN PLACE
IRVINE

KA12 9BH

Next of Kin:
Fraser

Other Relative

Ethnicity Scottish

Religion None

Attendances in last 12mths
0

Total Attendances Count
9

Phone Numbers:
Home: 07468337186

Employer/School
Not at School

Accompanied By:
Unaccompanied

Special case

Triage Time 12:27 **Triage Nurse** Sandra Reid **Triage Group** ~~Orange~~ yellow

Resp Rate	02 Sat%	PFR
17	98	

Pulse	BP	E	M	V
93	193 /92			

Triage details
Left sided chest pain. Patient reports tingling and numbness to left arm

Allergies: **No Known Allergy**

Treatment
ECG

BMstix	Alcohol	Temp	Weight
		36.3	

Special Needs
NONE

Visual Acuity
R L

Pain Score (Triage) 1

Pain Score (Discharge)

Re-assess in 15 30 60 minutes

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed..... Witness..... Witness.....

I give consent for details of my injury to be given to the Police.

Signed.....

Disch A+E clinic Paed Tr. # eye ENT Max Facial Ward OP Ward IP

*1406650854

AN Level Bed 10

Drug	Dose	route	time/frequency	signature	quantity/given by

PVC1	Size/Colour	Location	Initials	PVC2	Size/Colour	Location	Initials

	Device	Flow Rate l/min	%O2 for Venturi	Target SpO2	Prescribed by	Started by	Stopped by
Oxygen							
Changed to							

DOCTOR / ENP: ~~LOUISE MACLEOD CTF~~ Time: ~~12.56~~

CNN 7277270 1325

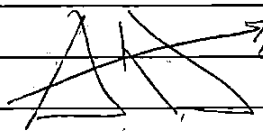
(51) Left sided paraesthesia & left chest pain

HPC Since Sunday (3 days ago) tingling down left arm
feels like it is originating left side of head, down back of neck into left arm
Also states tenderness over lateral left chest wall, post axillary line, rib 5-6
No autonomic features such as syncope vomiting, sweating

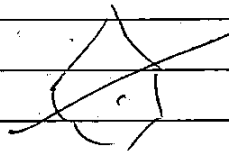
BACKGROUND Multiple issues which he seems to avoid addressing
→ Victim of RTA, multiple head injuries, end of last year, but signed himself out of QEUH
→ Urinary frequency, given abx for prostatitis but didn't take them
→ Previous symptoms like this, MRI screen negative but given appointment for exercise tolerance test, did not attend.

RMH: Erectile dysfunction Smoker — 15-15 roll-ups/day
Alcohol x5

C/o chest. Tingling sensation.



RR 14 SpO2 98% (A) HS I+II+0 pulse 80 reg. BP 140/90
warm well perfused



BS/-

ECG — high take off V2-V3 : Sinus rhythm
NAD acute

GCS 15/15 Subjective paraesthesia in L arm.

Normal power/tone all 4 limbs No photophobia or neurosymptoms.

CN II → XII intact. PERLA. Unable to elicit symptoms on lat. reach forces.

XH-16-048324-1

CHI Number: 1406650854

NHS Ayrshire & Arran

Accident & Emergency Nursing Documentation Form

SITUATION

GALLOWAY Stephen
28 REDBURN PLACE
IRVINE
KA12 9BH

DOB: 14/06/1965

Date: 24 Aug 2016
Time: 12:12

Additional information for admission complaint:
Left sided chest pain. Patient reports tingling and numbness to left arm

Receiving Nurse(s): SKED / _____ / _____

BACKGROUND

Relevant PMH relating to presenting complaint:

_____
_____
_____

Allergies: NKDA
Warfarin: yes/no/unknown
Insulin: yes/no/unknown

Next of Kin details: (if difference from A&E Card)
Name: _____
Relationship: _____
Address: _____
Telephone no: (if diff from above) _____
Consent to displaying personal info: Yes No

With patient: Yes/No
To be contacted?
If yes-time contacted_____
If no - reason _____

ASSESSMENT

MEWS/PAWS score: 0
GCS: 15/15

Name band in situ: Y/N
Own medications Y/N
Belongings taken for safe-keeping: Y/N
Cognitive Impairment: Yes/No

Any medications given by paramedics
_____
_____
_____

O2 therapy: yes/no Amount: _____

RECOMMENDATION

XH-16-048324-1 **CHI Number:** 1406650854

Treatment plan/Nursing Notes:

Date & Time	Nursing Notes
	E.C.G. Y/N Paged on arrival
	X-Ray Y/N
	I.V. cannula in situ: Y/N
	Bloods Obtained: Y/N
	Commenced on pathway Y/N
	Waterlow Score if req'd : ___
	Isolation Y/N
24/8/16 1230	- Anaest review ECG obtained
1415	AKI w. Referred to CAU

Transferring Nurse Signature: _____ Receiving Nurse _____

Time of transfer: _____ Relatives aware yes/no

XH-16-048324-1

Write or attach label

HCR Number:

CHI Number: 1406650854

Surname: Galloway **Sex:** Male

Forename: Stephen

Address: 28 REDBURN PLACE, IRVINE KA12 9BH

Date of Birth: 14 Jun 1965

MEDICAL CONTINUATION SHEET

DATE	
24/8/16	CAN C6/7 ?
	Imp Non cardiac pain. Bloods excluded though as has risk factors. Defaulted on prev. referral for GTT. ? migraine ? cervical pathology.
	P d/w Dr C. McRoberts (cons) → refer medical team Bloods and troponin sent CXR C-spine xray Refer medical team. CAN

Forename: Stephen **Surname:** Galloway

Date : 24 Aug 2016

DATE		

NHS Ayrshire & Arran

Acute Medicine Assessment Proforma

Write or attach label
CHI No 1406650854
Surname: Galloway
Forename: Stephen Sex:
DOB:

Date: 24.8.16	Time: 1640
Referral source: ED.	Receiving Consultant:

Presenting Complaint

51♂ Left arm paraesthesia.
Left scalene pain on movement radiating along C6/7 distribution.
Recurrent paraesthesia + neuropathic pain intermittently for 4-5 months.
Denies loss of fine motor control.
Denies chest pain on this presentation but defaulted in recent months from ETT for exertional angina (good ex tol)
No systemic cardioresp features today.

Alcohol excess
- Suffers mild withdrawal features
- No prev seizure activity
- Last drink Sunday evening

Painter + decorator - denies alcohol intake at work.

Past Medical History

RTA last year - Multiple head injury
No memory of event
Self discharged.

Alcohol XS - Weekend binges.

ACUTE MEDICINE

Multidisciplinary Medicines Reconciliation

Must be started by admitting Clinician within 24 hours

Source of information (use at least two sources) (Tick)

Patient	☑	Emergency Care Summary	☐
Relative / Carer	☐	Nursing Home Chart	☐
Patient's Own Drugs	☐	Previous Discharge Letter	☐
GP Referral Letter	☐	Repeat Prescription	☐
GP Practice	☐	Other (please specify)	☐

Admission Medicines			Action Note: Unless otherwise indicated below, medicines should be continued on prescription sheet				
Name, Form, Route (specify if not oral)	Dose	Frequency e.g. 3X	Suspend	Amend	Stop	Comments (if medicine suspended, amended stopped or inaccurate)	Pharm initials if change
Nil							

OTC / Herbal / Homeopathic / Illicit substances	Further information e.g. compliance aid, recent discontinued medicines

Adverse Reactions / Allergies Non known ☑ or

Medicines / Substance	Reaction

Are you satisfied this medication history is complete and accurate? YES ☐ NO ☐

If NO what further action is necessary (Contact GP etc) ..... Tick when resolved ☐

Pharmacist review signature ..... Date/Time ..... Beep No .....
(Initial changes / additions above)

Write or attach label

CHI No .....

Surname: .....

Forename: ..... Sex: .....

DOB: .....

Family History

Social History (As relevant)

Works as: Painter + decorator.

Lives with: Partner + daughter

Mobilises using:

Home Care: Usually independant

Family Support:

Recent Travel:

Functional Capacity: (eg. climb a flight of stairs?) Limited by recent hamstring injury. Previous angina like tightness at ~200yds

Alcohol (units/wk): Variable ~120 eg. (bottle morgans + crate beer on Sunday eve)

Smoker: (Yes) / No / Ex

ystematic Enquiry (As relevant)

Irritative urinary symptoms
- prev prescribed oral Abx
- did not take

No weight loss.

Weight loss / Appetite
Cardiovascular
Respiratory
Gastrointestinal
Urinary
Neurological
Musculoskeletal
ENT / Eyes
Skin
Endocrine
Gynaecology
Mental Health

Physical Activity screening:

Does the patient undertake 30 minutes of moderate physical activity 5 days per week?

Yes ☐ No ☐ If no, consider referral to local council physical activity advice program

ACUTE MEDICINE

General Examination

Temp: Pulse: 90 Sinus RR:

SpO_2: % FiO_2: (mask/NP)

BP - Lying: /

Standing(1min): /

Calves:

Delirium and Cognitive Assessment

4AT score _____ Use if over 65 or confused

Nursing staff will do this on admission; transcribe from their admission document.

The 4AT score helps distinguish delirium from cognitive impairment. Delirium is more likely in the acute setting.

Score ≥ 4: delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: unlikely delirium or cognitive impairment

If ≥4 then commence Delirium Pathway

Cardiovascular Examination

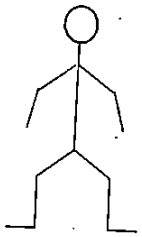
HS: I + II - No murmurs.

Heaves / Thrills

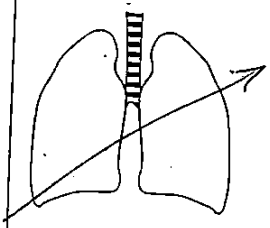
Pulses:

JVP: ←→

Oedema: No



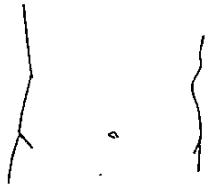
Respiratory Examination



Nil focal
Good AE throughout.

Peak flow:

Abdominal Examination



Soft throughout
No Distension / peritonism

Bowel sounds: ✓

PR:

General Neurological Examination

GCS: 15 /15 (E___/4, M___/6, V___/5)

Gait? Tremor? Meningism?

Peripheral and Cranial Nerve Examination

	RUL	LUL	RLL	LLL
Pronator drift	No	→	-	-
Tone	(N)	→	→	→
Power	5/5	→	→	→
Reflexes	(N)	→	→	→
Sensation	Intact throughout.			
Co-ordination				
Plantar reflexes				

Grip strength 5/5 bilaterally
Normal sensation currently.
No paraesthesia.
Describes total (L) arm paraesthesia not style cervical dermatome ? plexus.

Write or attach label

CHI No .....

Surname: .....

Forename: ..... Sex: .....

DOB: .....

Improving Sepsis Survival: Use if infection suspected *and* SIRS ≥2 or MEWS ≥ 4

Systemic Inflammatory Response Syndrome

- Temp >38° or < 36° ☐
- White cell count >12 or < 4 ☐
- Heart rate >90 min^{-1} ☐
- Respiratory rate > 20 min^{-1} ☐
- Acutely altered mental state: (4-Point AMT ≤ 3) ☐
- Bedside glucose >7.7 $mmoll^{-1}$ (without Diabetes) ☐

Sepsis Six

Must be complete within 1 hour suspected sepsis or SIRS criteria met.

1. **Antibiotics** (IV) as per local guidelines ☐
2. **Cultures** (Blood and relevant) ☐
3. **Oxygen** to achieve Sats >94%& ≤ 98% ☐
4. **Fluid** (IV) (500ml / hour or 20ml/kg stat if organ dysfunction present) ☐
5. **Lactate** ☐
6. **Monitor urine output** (Catheterise if organ dysfunction apparent) ☐

No obvious source? Check throat, ears, joints, pressure sores, IV cannula/central line sites, remove dressings, consider endocarditis or foreign body (e.g. tampon). Consider possible non-infective cause (e.g. pancreatitis, transfusion reaction, trauma and burns).

***If Severe Sepsis suspected** (Lactate ≥ 4mmoll^{-1}) contact senior medic on-call /ERT/H@N, consider transfer to Medical HDU, Medical High Care or ITU referral. Septic patients require regular review by senior medic on-call /ERT/H@N; patient must be handed over accordingly.*

Relevant Investigations

ECG: Sinus rhythm. High take off V2-3.

CXR:

Urinalysis:

Leucocytes:
Nitrites:
Protein:
Blood:
Glucose:
Ketones:

Relevant Bloods: Trop <0.03. Mg 0.76. WCC 13.0 CRP

ABGs:

ACUTE MEDICINE

Adult Medical Assessment Venous Thrombo-embolism (VTE) Prophylaxis Tool

[ADTC 213/2]

Do Not Use in Acute Stroke

Risks for thromboembolism (tick if apply)

- ☐ Age >60 years
- ☐ Active cancer or cancer treatment
- ☐ Any significant medical illness
  (e.g. cardiac, metabolic, endocrine, or respiratory disease; acute infection; inflammatory condition)
- ☐ Critical care admission e.g. HDU/ITU
- ☐ Dehydration
- ☐ Known thrombophilia
- ☐ Obesity (BMI >30)
- ☐ Personal history or first degree relative with a history of VTE
- ☐ Pregnancy or < 6 weeks post-partum
- ☐ Significantly reduced mobility for 3 days or more
- ☐ Use of hormone replacement therapy
- ☐ Use of oestrogen-containing contraceptive therapy

→ **No Risk Factors** ☑

→ **No prophylaxis required**
- Review decision 3x weekly

↓

1 or more Risk Factors

↓

Contraindications to Dalteparin (tick if apply)

- ☐ **Lumbar Puncture**/Epidural/Spinal Anaesthesia in previous 4 hours *or expected within next 12 hours*
- ☐ Any other procedure with high bleeding risk expected during this admission (including neurosurgery, spinal or eye surgery)
- ☐ Active bleeding
- ☐ Acute stroke
- ☐ Acute gastro-duodenal ulcer
- ☐ Acquired bleeding disorders e.g. acute liver disease
- ☐ Previous Heparin Induced Thrombocytopaenia (HIT)
- ☐ Thrombocytopaenia (Platelets $<75x10^9/L$)
- ☐ Concurrent use of **any** other anticoagulants (e.g. Warfarin)
- ☐ Uncontrolled hypertension >230/120 mmHg
- ☐ Untreated inherited bleeding disorders
- ☐ Any other concern (document in case notes)

→ **Any Contraindications** ☐

→ **Do not prescribe LMWH**
- Consider Anti Embolic stockings.
- Review decision 3x weekly

↓

No Contraindications ☐

↓

Please prescribe Dalteparin 5000 units subcutaneously once daily ☐
- FBC (platelets) to be checked on day 0 and day 1
- Review VTE prophylaxis 3x weekly

NB. reduction of prophylactic dose NOT required for patients with renal impairment (eGFR <30 ml/min)

Discussion with patient regarding risk of VTE & risks/benefits of LMWH ☐

☐ **Acute Coronary Syndrome** should receive treatment dose Dalteparin

☐ **Suspected DVT or Pulmonary Embolism** should receive treatment dose Dalteparin, until excluded.

NB. treatment dose LMWH should be reduced by 20% if eGFR <30 ml/min – see ADTC 75

Write or attach label

CHI No: .....

Surname: .....

Forename: ..... Sex: .....

DOB: .....

Impression • Differential Diagnosis • Problem List

(1) Brachial plexus / cervical nerve root entrapment. - Multiple risk factors.

(2) Exertional angina.

(3) Alcohol XS. (4) Concurrent simple UTI

Management Plan

All investigations listed must be annotated in a way that makes it clear if suggested, requested or performed.
Example: *"CT- requested on PMS* ☑"; *"Urinalysis – awaited* ☐"

1. Nerve conduction studies.
2. C-spine flex/extension views.
3. May well need OP MRI neck + neuro input
4. ETT + cardio f/u.
5. Vit B12 / follate / ferritin / bone profile + neuropathy screen
6. Watch for alcohol withdrawal - diazepam withdrawal protocol.
7. Urine Cx + oral Abx if indicated.

All Patients	
Blood results reviewed and printed:	☑
VTE prophylaxis assessed:	☑
Investigations requested:	☑
In-patient prescription chart complete:	☑

Considerations	
Sepsis 6?	☐
Adults With Incapacity?	☐
DNA-CPR?	☐
HIV test?	☐

Name & grade (ID stamp): Casey CTF Page: 3273 Date: 24.8.16

Signature: Ward: CAU Time: 1710

ACUTE MEDICINE

Pneumonia

CURB65 Score

C	Confusion (4 point AMT ≤ 3)	1
U	Urea >7 mmol/L	1
R	Respiratory Rate >30/min	1
B	Systolic BP <90 mmHg	1
65	Age greater than 65	1

Score 0 - 1 = Mild = PO Abx
Score 2 = Moderate = IV Abx
Score ≥ 3 = Severe = IV Abx

Always refer to local antibiotic policy

Use clinical judgement (e.g. bilateral pneumonia, degree of hypoxia).

Pulmonary Embolism

Simplified Geneva score

Age >65 years	1
Previous DVT or PTE	1
Surgery or fracture in last month	1
Active malignancy (or cure <1yr)	1
Unilateral lower limb pain	1
Haemoptysis	1
Heart rate 75 to 94 bpm	1
Heart rate >94 bpm	+1

Score ≤ 2 → for D-Dimer
Score > 2 → not for D-dimer, for appropriate imaging eg V/Q or CTPA

Deep Vein Thrombosis

Modified Wells

Active malignancy (or Rx ≤ 6mo)	1
Paralysis or plaster	1
Bedridden >3/7	1
Vein tenderness	1
Entire swollen leg	1
Difference in calf >3cm	1
Unilateral oedema	1
Previous DVT	1
More likely diagnosis	-2

Score < 2, low risk, for D-dimer
Score ≥ 2, high risk, for Doppler ultrasound

Upper GI Bleed

Glasgow Blatchford Score

Criterion	Male	Female	Score
Hb (g/dL)	120-130	100-120	1
	100-120	-	3
	<100	<100	6
Urea (mmol/L)	6.5 - 8		2
	8 - 10		3
	10 - 25		4
	>25		6
Systolic BP	100 - 109		1
	90 - 99		2
	< 90		3
Pulse ≥ 100	Present		1
Melaena	Present		1
Syncope	Present		2
Liver	Present		2
CCF	Present		2

Score 0 – 1; consider early discharge
Score >6 = 50% likely need intervention

Alcoholic Hepatitis

Glasgow Alcoholic Hepatitis

Age	< 50	1
	≥ 50	2
WCC	< 15	1
	≥ 15	2
Urea	< 5	1
	≥ 5	2
INR	< 1.5	1
	1.5 - 2	2
	> 2	3
Bilirubin	< 125	1
	125 - 250	2
	> 250	3

If total > 9, consult Gastro about steroids

Maddrey's score

= (4.6 x (PT test - control)) + Bilirubin ÷17
(If total >32, consider steroids)

Acute Pancreatitis

Imrie Severity Score

PaO_2 < 7.9 kPa	1
Age > 55	1
WCC >15 x10^9/L	1
Calcium < 2 mmol/L	1
Urea >16 mmol/L	1
LHD > 600 IU or AST > 200 IU	1
Albumin < 32 g/L	1
Glucose > 10 mmol/L	1

If considering pancreatitis, request surgical review
If the score ≥ 3, severe pancreatitis likely: contact surgeons & consider Surgical HDU / ITU

Anion Gap

= $(Na^+ + K^+) - (Cl^- - HCO_3^-)$

Used to assess the contribution of unmeasured anions to acidosis. Normal range 10-20 mmol/L.

TIA Assessment

$ABCD_2$ Score

Age > 60	1
BP >140 / 90	1
Speech disturbance	1
Unilateral weakness	2
Duration 10-59 min	1
≥ 60 min	2
Diabetes	1

Score <4; start aspirin 300mg.
Score ≥4; start aspirin 300mg & specialist assessment <24h; carotid doppler / brain imaging.

Oxygen Therapy

BTS Guidance

No risk of chronic hypercapnic respiratory failure:
Aim sats 94 – 98%
If sats < 85% initially use trauma mask 15L

Risk of chronic hypercapnic respiratory failure/COPD
Aim sats 88 – 92%
Initially use Venturi mask 28%

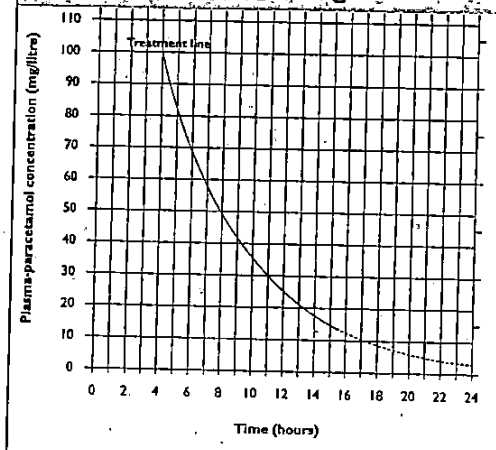
Non-Valvular AF anticoagulation

CHA_2DS_2 Vasc

Heart Failure	1
Hypertension	1
Age 65 - 74	1
Age ≥ 75	2
Diabetes	1
Previous TIA or stroke	2
Vascular disease	1
Female	1

If ≥1, for Warfarin
Consider LMWH & novel oral anti-coagulants.

Paracetamol Overdose guidance



Where level is above treatment line, give N-acetylcysteine (Parvolex)

Treatment with N-AC: (1) ascertain patient's weight and (2) use adult dosage table to determine the appropriate volume of N-AC to be added to the infusion fluid for each of the 3 infusion periods.

For full information refer to Toxbase & BNF:
Emergency treatment of poisoning > Specific drugs > Paracetamol.

Therapeutic excess:

Give N-AC if jaundice, hepatic tenderness, or ingested >150mg/kg in 24hrs.

Consider N-AC if ingested 75-150mg/kg in 24 hrs if glutathione deplete (eg. chronic debilitating illness, malnourished patients, ie. not eaten for a few days, eating disorders, cystic fibrosis, AIDS, cachexia, alcoholism, cirrhosis)

Write or attach label

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr A Sharma
MRN: XHI468158

Consultant Opinion Date: 25/8/15 Time: 1023 Ward: CAU/10

ST
- Hx in detail by Dr Caley
- Consistent ? R. nerve root avulsion / brachial plexus fracture 2° to his fall.
- (N) pain on UL & hand numbness
- Bloods wnl.

~~A: ? Cervical nerve root avulsion / brachial plexus fracture~~

A: ? Cervical nerve root avulsion / brachial plexus fracture.

(P) D/C

OP MRI

NCS

Amitriptyline long @ night

OP ECT as scheduled pre-appt.

Dr Mahanth Manuel
Consultant Physician
Acute Medicine
GMC 6041033 Page 3763

ACUTE MEDICINE

Clinical Governance

Medicine Reconciliation complete	☐
VTE Prophylaxis Assessed & prescribed	☐
Antibiotics as per microbiology policy	☐
DNA-CPR status considered	☐
Escalation of care/ceiling of treatment considered	☐

Discharge / Allocate:

EDD: <24hr 24-72 hrs >72 hrs

Name (ID Stamp):

Signature:

Continuation

CROSSHOUSE HOSPITAL
EMERGENCY DEPARTMENT

NHS Ayrshire & Arran

BBS/4

A/E No: **XH-15-004043-1**

CHI No: **1406650854**

Date: **21 Jan 2015** Time: **17:38**

Consultant: **Dr David Chung**

GP
Dr. A AUGUSTINE
FREW TERRACE SURGERY
9 FREW TERRACE
IRVINE
AYRSHIRE
KA12 9DY

Incident Date: **21 Jan 2015**
Incident Time: **17:38**

Martial Status: **Single**

Sex: **M**

Next of Kin:
Fraser

Ethnicity

Religion Church of Scotland

Attendances in last 12mths **0**

Total Attendances Count **8**

Accompanied By:
Unaccompanied

Special case

GALLOWAY

Stephen

Date of Birth: **14 Jun 1965** Age: **49 Years**

Address:
28 REDBURN PLACE
IRVINE

KA12 9BH

Phone Numbers:
Home: 07501988224

Employer/School
Not at School

Triage Time 17:45 **Triage Nurse** DAVID HITCHEN **Triage Group** Orange

Resp Rate | 02 Sat% | PFR

Pulse | BP

E M V

Allergies: **No Known Allergy**

BMstix | **Alcohol** | **Temp** | **Weight**

Visual Acuity
R L

Pain Score (Triage) 97

Pain Score (Discharge)

Triage details
gp ref CP

MEWS = 0

Treatment

ECG

Special Needs

Re-assess in 15 30 60 minutes

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed.....Witness.....Witness.....

I give consent for details of my injury to be given to the Police.

Signed.....

Disch | A+E clinic | Paed Tr. # | eye | ENT | Max Facial | Ward OP | Ward IP

*1406650854

CDU

A/E No. XH-15-004043-1

Drug	Dose	route	time/frequency	signature	quantity/given by
ASPIRIN 300mg		O	1845		ZT

PVC1	Size/Colour	Location	Initials	PVC2	Size/Colour	Location	Initials

	Device	Flow Rate l/min	%O2 for Venturi	Target SpO2	Prescribed by	Started by	Stopped by
Oxygen							
~~Changed to~~							

DOCTOR/ ENP: DAVID HEWITSON (LAT Time: 1830.

ASSIGN Score – prioritising prevention of cardiovascular disease

ASSIGN Cardiovascular Risk Score Version 1.5

Name/ Patient ID	galloway
Current age	49
Sex	◉ M ○ F
Scottish Postcode	KA12 9BH
Family history of CHD/Stroke	◉ N ○ Y
Is the subject diabetic?	◉ N ○ Y
Rheumatoid arthritis?	◉ N ○ Y
Cigarettes smoked daily or equivalent	15
Systolic Blood Pressure	140
Total cholesterol	5.1
HDL Cholesterol	1.07

ASSIGN Score: 14

ASSIGN score below 20 is not currently high risk, implying general preventive measures (nobody is free of risk) Repeat the scoring in 5 years or earlier, depending how high the current score is.

XH-15-004043-1

CHI Number: 1406650854

NHS Ayrshire & Arran

Accident & Emergency Nursing Documentation Form

SITUATION

GALLOWAY Stephen
28 REDBURN PLACE
IRVINE
KA12 9BH

DOB: 14/06/1965

Date: 21 Jan 2015
Time: 17:38

Additional information for admission complaint:
gp ref CP

Receiving Nurse(s): Hitch / _____ / _____

BACKGROUND

Relevant PMH relating to presenting complaint:

_____
_____
_____

Allergies: Nil
Warfarin: yes/no/unknown
Insulin: yes/no/unknown

Next of Kin details: (if difference from A&E Card)

Name: _____
Relationship: Gina Fraser (partner)
Address: _____
Telephone no: (if diff from above) _____
Consent to displaying personal info: Yes No

With patient: Yes/No
To be contacted?
If yes-time contacted _____
If no - reason _____

ASSESSMENT

MEWS/PAWS score: _____
GCS: 15

Any medications given by paramedics

_____
_____
_____

Name band in situ: Y/N
Own medications Y/N
Belongings taken for safe-keeping: Y/N
O2 therapy: yes/no Amount: _____
Cognitive Impairment: Yes No _____

RECOMMENDATION

XH-15-004043-1

CHI Number: 1406650854

Treatment plan/Nursing Notes:

Date & Time	Nursing Notes
	E.C.G. (Y)/N
	X-Ray (Y)/N
	I.V. cannula in situ: Y/N
	Bloods Obtained: Y/N
	Commenced on pathway Y/N
	Waterlow Score if req'd : ____
	Isolation Y/N
	No relatives present
21.1.15	ef rel C.P. assess
18.20	D/w/
	D ECG
	Referred to CDU
	Aspirin 300mg given

Transferring Nurse Signature: _____ Receiving Nurse _____

Time of transfer: _____ Relatives aware yes/no

XH-15-004043-1
DOB: 14/06/1965 Male
GALLOWAY Stephen
28 REDBURN PLACE, IRVINE
KA12 9BH
1406650854

NHS Ayrshire & Arran

Clinical Decisions Unit (CDU)- Admission Proforma
Non- Traumatic Chest Pain

Date: 21/1/15 **Time:** 1840.

Admitting Doctor: HEWITSON/LAT **Receiving Consultant:**

Presenting Complaint

- Chest discomfort last couple of days. Worse episode on Tuesday when out walking. Lasted couple of hours. Describes as a crushing/ heaviness in centre of chest
- Has had a cough with some brown sputum in past couple of days.

Time of onset- last episode ~ 1730 - 1800
Duration of chest pain-

History of pain (circle and insert score)

Time of onset:		**Duration**		Pain score	
Symptom / score	**3**	**2**	**1**	**-1**	**G score**
Site of pain	Substernal	Precordial	Neck, jaw, epigastrium	Apical	
Radiation		either arm	Shoulder, jaw, neck, back		
Character of pain	Crushing pressing squeezing	Heavy, tight		Stabbing catching	
Severity of pain		severe	moderate		
Influenced by			GTN	Breathing body position	
Exertional angina		yes			
Vomiting or nausea		yes			
SoB		yes			
Sweating		yes			
				Total G score	
Other pain details Aggravation Relieving Intermittent increasing					

Patient's name/addressograph

Previous Medical History

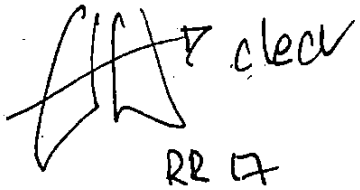
nil

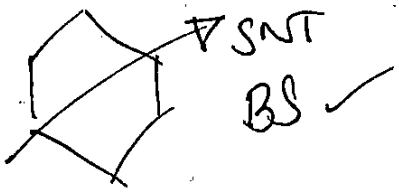
Known to have IHD- Yes/No

	Brief details	
Family history		Y/N
Smoker – cigs/day	15 roll-ups / day.	Y/N
History of Hypertension		Y/N
History of Hyperlipidaemia		Y/N
Sedentary lifestyle- exercise/ activity		Y/N
Heavy Drinker		Y/N
Diabetes		Y/N
BMI > 30		Y/N
Total risk factors		

Clinical Assessment/ Systemic Enquiry/ Examination

well, comfortable.





75bpm
140/75
36.5°C.

calves SNT
H/S 1+11+0

Pat XH-15-004043-1
DOB: 14/06/1965 Male
GALLOWAY Stephen
28 REDBURN PLACE, IRVINE
KA12 9BH

Clinical Impression/ Management Plan

Venepuncture- FBC ☑ U+Es ☐ Glucose ☑ Lipids ☑ Admission Troponin (if pain > 12h ago) ☑
Chest XRay- Yes/No
Admission Troponin T- Yes/No
12 hour Troponin T (12 hours from onset) due- repeat trop again at 0600

Imp: ? LRTI, exclude cardiac.
D/w D. Mckenzie - plan as above, repeat trop in morning.

Name: HEWITSON Signature: Date/ Time: 21/1/15 1845

Disposal

STEMI	Follow STEMI pathway	PCI / 4F
Persisting cardiac pain OR arrhythmia OR heart failure or SBP < 100 or / ST depression / other dynamic ECG change	Treat as high risk ACS	4F
Low risk chest pain not suitable for CDU (co-morbidity, can't discharge in < 24 hours, known IHD with follow up 2+ times a year, recent abnormal cardiac test)	Treat as appropriate	3E
Pain resolved, low risk ACS. Single episode > 20 mins. 3 episodes cardiac pain > 3 mins in last 3 days.	Low risk acute ACS	CDU Discuss with senior
Non cardiac pain	Treat as appropriate	Discharge

Patient's name/addressograph

Management protocol for chest pain

Clinical assessment in A&E

History Examination ECG BM Pain Score Chest X-ray

Category 1
Cardiac Pain
ECG - Stemi

→ **Transfer protocol for Primary Percutaneous Coronary Intervention (PPCI)**

Category 2
- Persisting cardiac pain
- ST depression(>1mm) or dynamic ECG changes
- Cardiac Failure
- SBP<100
- Significant Arrhythmia

→ Treat as high risk Acute Coronary Syndrome (ADTC)

→ **ADMIT CCU(4F)/ Station 5**

Category 3
Chest pain:
- Low risk ACS
- Single episode of possible ischaemic chest pain

Exclusion Criteria
- ☐ Significant Co-morbidity
- ☐ Discharge predicted > 24 hours

YES → **ADMIT AMAU**

NO → **ADMIT CDU**

Category 4
- Likely alternative diagnosis
- Known stable angina with no unstable features i.e. not increasing in frequency or duration

→ **DISCHARGE advice wit appropriate G.P follo up or TREAT APPROPRIATELY**

Management
- ☐ Troponin – 12 hours after the onset of pain
- ☐ ECG – 1 hour from ECG in A&E
- ☐ ECG - 12 hours from ECG in A&E
- ☐ ECG if recurrent or ongoing pain
- ☐ FBC, U's & E's, Glucose, Lipids,
- ☐ Appropriate drug treatment and pain relief (ADTC)
- ☐ Cannulation

TnT > 0.03
and/ or
ECG changes
and/ or
Recurrent pain

TnT > 0.03
No new ECG changes
and/or
Painfree

→ **ADMIT 4E/ Station 6 Cardiology**

Tnt –ve

- ☐ Diabetes
- ☐ Previous CABG
- ☐ Known angina increasing in frequency
- ☐ >2 Coronary Risk Factors
- ☐ ASSIGN

→ Consider IP or OP ETT during final senior review

ST- elevation Myocardial Infarction (STEMI) protocol
Dynamic ECG changes- STEMI- follow Optimal Reperfusion Instructions. Discuss further management with Hairmyers/ Golden Jubilee- transfer within 6 hours. (ADTC)

☐ Aspirin 300mgs ☐ Clopidogrel 300mgs ☐ LMWH (ACS dose) (ADTC)

☐ Oxygen (where appropriate) ☐ GTN (where appropriate)

☐ Morphine ☐ Metoclopramide

In pt ETT
+ve - Copy of discharge letter must be sent to cardiologists
Medicines Management as per ADTC
-ve – Discharge to GP
OP ETT
Copy to be sent to cardiologists
Medicines Management as per ADTC
Pt not suitable for ETT
Copy of discharge letter to cardiologists

Pati XH-15-004043-1
DOB: 14/06/1965 Male
GALLOWAY Stephen
28 REDBURN PLACE, IRVINE
KA12 9BH

1406650854

Clinical Decisions Unit (CDU)
Non- Traumatic Chest Pain

Date: 21/01/15 **Time:** 1910

Next of Kin: Gina Fraser **Relationship:** ex partner **Contact No:** 36 Dantonknoll.
Patient contact details: 01501988224

Patient consent to display limited information about care: Y
Date: 21/1/15
Patient responsible for own valuables: Y
Date:

Summary of Results

	Time	Result	Signature
ECG in ED	1625	SR, nil acute.	
CXRay	1850	lungs clear, no pneumothorax	
ECG 1 hour after ECG in ED or if pain ongoing or returns	1935	SR, nil acute	
U+E's			
FBC			
Blood Glucose and Lipids			
ECG if recurrent pain			
ECG12 hours after ECG in A&E or if pain ongoing or returns)			
Troponin 12 hours from onset of pain			
D-dimer (if reqd)			
ASSIGN risk stratification	0840	1490	

NHS
Ayrshire
& Arran

Multidisciplinary Medicines Reconciliation Form
Must be started by admitting Clinician within 24 hours

Source of Information (Use at least two sources) (Tick)

itient
lative/Carer
tient's Own Drugs
Referral Letter
Practice

- [x] Emergency Care Summary
- [ ] Nursing Home Chart
- [ ] Previous Discharge Letter
- [ ] Repeat Prescription slip
- [ ] Other (Please state)

Patient's name/addressograph

Admission Medicines			Action Note: Unless otherwise indicated below, medicine should be continued onprescription sheet				
Name, Form, Route (specify if not oral)	Dose	Frequency eg 3X	Suspend	Amend	Stop	Comments (if medicine suspended, amended stopped or inaccurate)	Pharm initials
NO meds							

TC/ Herbal/ homeopathic/ illicit substances	Further information eg compliance aid, recent discontinued medicine

Adverse Reactions/Allergies
None Known [x]

Medicine/ Substance	Reaction

Are you satisfied this medication history is complete and accurate? **Yes** ☐ **No** ☐

If **No** what further action is necessary (Contact GP etc) .....
Tick when resolved

Patient Name	CHI	Date Of Birth	Age
Stephen Galloway	1406650854	14/06/1965	49

Source of Information

Patient	✓	Relative / Carer		Patient's Own Drugs		GP Letter		GP Practice	
Care home / MAR Chart		Previous Discharge Letter		Repeat Prescription Slip		Community Pharmacy		Other (Please State)	

Allergy Description	Date Recorded	Comments
NKDA		

Acute Medication (including those greater than 30 days)

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Continue	Withhold	Stop	Comments

Repeat Medication

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Continue	Withhold	Stop	Comments
	Tadalafil	5 mg Tablets	N/A	TO BE TAKEN AS DIRECTED	14-Jan-2014	09-Jan-2015			✓		not in hospital
	Lansoprazole	30 mg Capsules (Gastro-Resistant)	N/A	ONE TO BE TAKEN EACH DAY	21-Feb-2014	22-Jul-2014				✓	old
	nil else	oTC	/	he							

Patient Name	CHI	Date Of Birth	Age
Stephen Galloway	1406650854	14/06/1965	49

Repeat Medication

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Continue	Withhold	Stop	Comments

Compliance Device	Name and telephone number for community pharmacy

Completed by	Designation	Grade	Date	Time	Contact Number

Reviewed by	Designation	Grade	Date	Time	Contact Number

Criteria for Discharge	☐ Cardiac markers normal (Troponin < 0.03) after onset of pain ☐ ETT as per protocol (G- score of ≥ 11 or 3+ risk factors) ☐ No changes in ECG's ☐ Painfree ☐ Follow up arranged if required ☐ Patient advised of diagnosis and treatment plan ☐ Social circumstances permit discharge ☐ Letter to G.P.
Criteria for admission to CCU (at any time)	☐ Troponin > 0.03 and/or ☐ ECG changes and/or ☐ Recurrent pain
Criteria for admission to 4E	☐ No New ECG changes ☐ Painfree

Risk Assessment	**Signature**	**Date/ Time**
MRSA- mandatory	KV	21/1/15 1920
Cotsides- mandatory	K	21/1/15 1920
Falls- over 65/ history of falls		
MUST- consider individual patient. Must complete within 24 hours		

Clearly document if in your professional judgement you decide the risk assessment is not required.

Patient's name/addressograph

Free text page (for use by all staff in CDU)

Date/Time	Comments/ Notes	Signature
21/01/15 1925	GP referral with chest pain chest pain started a few weeks ago, Worsening over the past couple of days. felt crushing with shortness of breath. Also felt dizzy. lasted for 25minutes while out walking	
	Observations as stated. MEWS 0	
	Diet and fluids taken	
	Independently mobile.	
	No allergies	
	1 hour ecg obtained	
	Bloods obtained in A&E	
	results awaited.	K
21/1/15 23[or]	Pt Comfortable at present time.	
	No further Complaints of Pain. Has	
	Signed Smoking disclaimer and	
	been outside. Pt had Crisps and sweets	
	from Vending machine as well as	
	toast and coffee prior to Setting.	
	Mews = 0 as charted. No new	
	issues raised at time of report.	Joanna

CHI: 1406650854,
Galloway, Stephen
66 Garnock Street
Dalry
KA24 4AW
14/06/1965
Dr ML Permah
MRN: XHI468158

Date/Time	Comments/ Notes	Signature
22/1/15 06[00]	pt Comfortable, Slept Well. ECG (12°) done at 06:00am, bloods obtained for Trop T amount result. Mews: 0 as charted. Patient then went out for cigarette. Jasmin.	
22/01/14	0930 NIK Mr Chung (LED Consultant)	
	- history reviewed,	
	- 2/52 ^10, chest pains, no pattern, has had a few nosebleeds, varying lengths of time for chest pain, sometimes nauseated dizzy ? anxiety related.	
	- SMOKED 15 CPD	
	- no ^10 fairly coronary problems	
	- recent catarrh, pains to base of back, cough	
	- CXR - nil focal	
	- ECG - nil acute	
	- TROPT - <0.03	
	- assign - 1670	
	exam: nil focal	
	-	
	plan - rpt ETT.	
	- if normal home — IKn	
		FCP55Es

Patient's name/addressograph

Free text page (for use by all staff in CDU)

Date/Time	Comments/ Notes	Signature
22/01/15	11[20] admitted to RTT, managed 12 mins, 100% TRK, NO CHEST PCA, NO STENTED, reviewed by Mr Chung, airway have, no further follow up req. — KW.	
22/01/15	Patient independent with ADLS	8C6035LC.
1130	Obs as charted MEWS 0	
	No pain	
	Settled in ward	
	Managing diet and fluids	
	No venflon in situ	
	Patient discharged. No concerns	KW

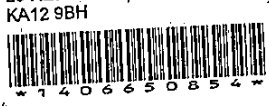
XH-15-004043-1

DOB: 14/06/1965 Male

GALLOWAY Stephen

28 REDBURN PLACE, IRVINE

KA12 9BH



K[illegible]rshire and Arran – Crosshouse Hospital

Clinical Decisions Unit – Discharge Sheet

Please document the patient's journey here:

Admitted to Ward(state ward)		Discharged home	
Reason for admission	CP	Date/Time discharged	
Time left CDU		Out-patient clinic (specify)	

If patient is discharged please complete the following checklist BEFORE discharge:

MOBILITY	PERSONAL CLEANSING AND DRESSING
Independent	Independent

EATING AND DRINKING	SOCIAL SERVICE (Does care package require to be recommenced) NURSING HOME
Normal diet and fluids	✓

DISTRICT NURSE	TRANSPORT
✓	OK ✓

I think it is important for you to know...	Patient counselled on present and new medicines YES ☐ NO ☐ Signature

COMMUNICATION WITH GP IMMEDIATE DISCHARGE LETTER given.	PATIENT INFORMATION LEAFLET ☐ awaiting ETT ☐ no ETT ☐ Negative ETT IP ETT.
OUT PATIENT ARRANGEMENTS MADE N/A	DISCHARGE ADVICE given

Discharging Nurse Signature.....Print Name.....

Date/ Time.....

STA0098 **CROSSHOUSE HOSPITAL - ACCIDENT AND EMERGENCY DEPARTMENT** (1)

Triage time 09:49 Triage nurse LESLIE Triage group Green

resp rate		sat O2%		PFR	
pulse		BP	/	GCS	

allergy: No allergy

BMstix	breath alcohol	temp

urine:

VA R L pain score 8

accompanied by: Unaccompanied

Triage details

assaulted last night, punched to right side of face, c/o pain and difficulty moving jaw

treatment

Analgesia given with instructions

I give consent for details of my injury to be given to the Police

Signed.....

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed.....Witness.....Witness.....

Surname: GALLOWAY
Forename: STEPHEN

marital status: S
sex: M

A/E No.: 00050169
Consultant: A Lannigan
date/time attendance: 09/12/2000 09:45

Date of birth: 14/06/1965
age: 35

Address: 8 CARMEL DR
SPRINGSIDE
IRVINE
AYRSHIRE

alt N

Post code: KA11 3AG

special case

this problem+total att: 2 + 1

GP: A ADRAIN
address: CROSSHOUSE CLINIC
GATEHEAD ROAD
CROSSHOUSE

KA2 0HU

phone: 1563521506

phone: NIL MOBILE 07994493817 4

incident: date/ time: 6 - 12 hours

next of kin: GEM MCFARLANE
address: 8 CARMEL DR
SPRINGSIDE
IRVINE
AYRSHI
KA11 3AG
relationship: Partner
phone: NIL

occup:
religion: Church of Scotland
employer:
school:

hospital number: H68158

NOT ON COMP. CLINIC LOCKED 23/8/17

disch | A+E clinic | paed tr. | # | eye | ENT | max facial | ward - OP | ward - IP | x-ray? Y / N

(PATIENT INFORMED 9/12) 14/12 @ 11.20 MAXFAX (HSLNO) DISMISSED 2nd DEAFNESS

Drug	Dose	route	time /frequency	signature	given by/quantity
CoCODAMOL 8/500	2	PO	4-6°/24	Frentico	QIDPRN

Time: 0950 DOCTOR: PRENTICE

35yo ♂

PC Assaulted last night – punched (R) side face.
c/o pain (R) jaw
Unable to open mouth fully.
No malocclusion
No numbness (R) face

OE Well.
(R) side face :- No swelling / bruising
Tender over TMJ and upper mandible
Unable to open mouth fully.
No palpable #. No dental malocclusion.
No sensory deficit.
CN VII intact.

X-Ray Mandible :- No fracture.
(inc. OPT)

Plan Analgesia & advice.
Max-Fax clinic Wednesday 13th.
(authorised by Dr Ness - SHO)

Frentico
(SHO)

STA0212

Surname..... XH 468158
Forenames..... GALLOWAY STEPHEN
Address..... 3 CARMEL DR
SPRINGSIDE
KA11 3AG
DR J MAGEE 14/06/1965
Ward or Dept. GATEHEAD ROAD CROSSHOUSE

DATE

14/12/00 Rep by ATE re: alleged assault
where pt sustained punches to face.

c/o some tenderness ① cheek
some discomfort when teeth
in occlusion

NPC 9/12/00

PMH - nil relevant

Medication

NKDA

OE nil ♂ note
occlusion - satisfactory ♂ stable

no Rx req'd

DDSCD,

MAXILLOFACIAL

DATE

Surname ..... HCR No. .....

For XH 468158

Add GALLOWAY STEPHEN
41 MAIN ROAD
SPRINGSIDE
KA11 3AN

D.B. 14/06/1965

Wa DR.W NICOLL
5A HENRIETTA ST
GALSTON
CHI

STA0238

DATE

25.11.99 Weight 11ST 5LB (72.1Kg)

MEDICAL

DATE

MEDICAL IN CONFIDENCE

ADMISSION FORM V3

MEDICAL RECORI

11/10

HOSPITAL CODE	HOSPITAL NAME	CASE RECORD NUMBER
A111H	CROSSHOUSE HOSPITAL	XHI-68158

DATE	TIME	TYPE	REASON	ADM./TRANS. FROM	INPAT./DAYCASE	DATE ON W.L.	W.L. TYPE	PATIENT CATEGORY
11/10/99	10:00	18	IR	43 ISMED	DC		8	5 NHS

WARD	S. FACILITY	SPECIALTY	CONSULTANT	FROM LOCATION	W.G.E.
ENDOSCOPY SUITE		GEN.SURG.EX.VASC.HR	C MORRAN		

PATIENT

TITLE SURNAME: MR GALLOWAY | FORENAME (1): STEPHEN | (2): | AGE: 34 | DATE OF BIRTH: 14/06/1965 | SEX: M | MARITAL STATUS:

ADDRESS: 41 MAIN ROAD
SPRINGSIDE

ALT./PREV. SURNAME:

OCCUPATION: U/E

C.H.I. NUMBER:

POSTCODE: KA11 3AN | TELEPHONE No.: NONE

OCCUPATION (HUSBAND/FATHER):

HEALTH BOARD OF RESIDENCE: Ayrshire and Arran

HAVE YOU LIVED IN THIS COUNTRY FOR PAST YEAR?

REF. G.P.

NAME: NICOLL | G.P. CODE: 2618816 SAC02 | PRACTICE: 80260|1 | S | N

CONTRACT No.: | FH STATUS:

ADDRESS: 5A HENRIETTA ST
GALSTON
01563 820424 | KA48HN

TEL No. | POSTCODE

REF.

NAME: NICOLL | G.P. CODE: 2618816 SAC02 | PRACTICE: 80260|1 | S | N

CONTRACT No.: | FH STATUS:

ADDRESS: 5A HENRIETTA ST
GALSTON
01563 820424 | KA48HN

TEL No.: AS ABOVE | POSTCODE

NEXT OF KIN

NAME: MISS GEM MCFARLANE

RELATIONSHIP: PARTNER

ADDRESS: A/A | A/A

DAY PHONE No. | NIGHT PHONE No.

MISC.

RELIGION: Ch.of Scotland

VISIT REQ. BY CHAPLAIN YES/NO: N

PENSION BOOK No.:

Admission

MAIN DIAGNOSIS | SPECIAL WARNINGS

OTHER CONDITIONS (D.G.2)

OTHER CONDITIONS (D.G.3)

SMR04 | SMR50

H. STATUS | PREVIOUS PSYCH. CARE | CONTRIBUTORY SOCIAL FACTOR

DISCHARGE SUMMARY

DATE	TIME	DISCH. TYPE	PATIENT CATEGORY	MANAGEMENT OF PATIENT	SPECIALTY	CONSULTANT CODE
11/10						

DISCHARGE DETAILS

DISCH./TRANSF. TO	READY FOR DISCH.	HOSPITAL: NAME	CODE	WARD	SPECIALTY	CONSULTANT CODE
3E				KP		MoMan

SMR04	TYPE OF CARE PROVIDED		ECT - 1st TREATMENT DATE		ECT - NUMBER OF TREATMENTS	

DIAGNOSES

		CODE	SPECIAL WARNINGS
MAIN DIAGNOSIS	Reflux Oesophagitis	K210	
OTHER CONDITIONS (D.G.2)	Erosions of oesophagus	K221	
(D.G.3)	Acute gastric ulcer	K253	
(D.G.4)	Gastritis	K297	
(D.G.5)	Past clo	B9688	
(D.G.6)			

AND OPERATIONS

		CODE	DATE
MAIN OPERATIONS	Endoscopy + clo	G451	11/10/99
OTHER OPERATION (O.P.2)			
(O.P.3)			
(O.P.4)			

ISOBEL ROBERTSON | 11/10/99 13:26 | LOCAL | NATIONAL

STA0098 **CROSSHOUSE HOSPITAL - ACCIDENT AND EMERGENCY DEPARTMENT** OA

Triage time 21:08 Triage nurse TRAIN Triage group Green

resp rate 12 | sat O2% 97 | PFR

pulse 88 | BP 140/83 | GCS 15

allergy No allergy

BMstix | breath alcohol | temp

urine

VA R L | pain score 3

accompanied by: Friend

Triage details

Vomited blood, this evening, PHM "Ulcers", used to take tagamet

UR 4-6 Bony 88
CR 104 Sat 92%
Na 142
K 3.7
Ca 1.04
treatment
Bp 130
Hb 14.3
WCC 11.2
Pl 323

I give consent for details of my injury to be given to the Police Signed.....

Against Medical advice I decline the treatment offered. I know this may affect my recovery.
Signed.....Witness.....Witness.....

Surname GALLOWAY
Forename STEPHEN

marital status S
sex M

A/E No. 99040936
Consultant MR M ZAIDI
date/time attendance 10/10/1999 21:08

Date of birth 14/06/1965 | age 34

Address 41 MAIN RD
SPRINGSIDE
IRVINE
AYRSHIRE
alt N
Post code KA11 3AN

special case

this problem+total att + 0

GP WS NICOLL
address 5A HENRIETTA STREET
GALSTON
KA4 8JW
phone 01563 820424

phone NIL

incident: date/ time 18 - 24 hours

occup UNEMPLOYED
religion Church of Scotland
employer
school

hospital number

next of kin. GEM MCFARLANE
address 41 MAIN RD
SPRINGSIDE
IRVINE
AYRSHIR
KA11 3AN
relationship Partner
phone NIL

disch | A+E clinic | paed tr. | # | eye | ENT | max facial | ward - OP | ward - IP | x-ray? Y / N

Drug	Dose	route	time /frequency	signature	given by/quantity

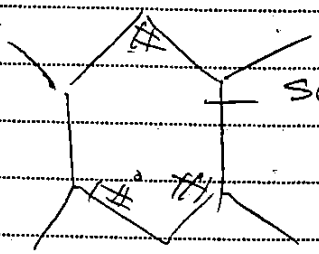
Time: 21. 30. **DOCTOR:** Mok

PC: Haematemesis. ×2.

HPC: Haematemesis ×2, Yesterday & today,
- Fresh Red Blood. Yesterday, Clot today
- ass w/ epigastric pain & heart burn.
- °Nausea.
- Had bis (N) 1 Can ō beer (d. - , No more than usu, previous heavy drinker, ~~&~~ Had Hogs ~~&~~ Sat
- °No Lower GI Sym.
- Had haematemesis previously ~~but~~ NO & was ix, ? Result for Ba Meal. Not been admitted to hospital.

DH = Nil.

O/E Obs → Normal.



Soft, slightly tender lower abdomen & epigastrium.

BS+ °Liver ° mass.

W access / FBC / UE / Glu / LFT / Bts / Amy ✓ CXR.

) Refer Medics ✓

Mok (SHO)

MEDICAL IN CONFIDENCE

ADMISSION FORM V3

MEDICAL RECORD

HOSPITAL CODE	HOSPITAL NAME	CASE RECORD NUMBER
A111H	CROSSHOUSE HOSPITAL	K1694F8

DATE	TIME	STOPE	REASON	ADM/TRANS METHOD	IN/P./DAYCASE	DATE ON W.L.	W.L. TYPE	PATIENT CATEGORY
10/10/99	17			PRIMARY			8	2 NHS

WARD	FACILITY		CONSULTANT	FROM LOCATION	W.G.E.
		GENERAL MEDICINE	JAFP		

MR/E SURNAME	FORENAME (1)	(2)	AGE	DATE OF BIRTH	SEX	MARITAL STATUS
GALLOWAY	STEPHEN		34	14/06/1965	M	

ADDRESS: 41 MAIN ROAD
SPRINGSIDE

POSTCODE: KA11 3AN

HEALTH BOARD OF RESIDENCE: Ayrshire and Arran

ALT./PREV. SURNAME

OCCUPATION: NONE

TELEPHONE No.

OCCUPATION (HUSBAND/FATHER)

HAVE YOU LIVED IN THIS COUNTRY FOR PAST YEAR?

C.H.I. NUMBER

NAME: NICOLL	PRACTICE: 80260|1	ADDRESS: 5A HENRIETTA ST GALSTON	
G.P. CODE: 2618816 SAC02	FH STATUS: S N	TEL No.: 01563 820424	POSTCODE: KA48HN
CONTRACT No.			
NAME: NICOLL	PRACTICE: 80260|1	ADDRESS: 5A HENRIETTA ST GALSTON	
G.P. CODE: 2618816 SAC02	FH STATUS: S N	TEL No.: 01563 820424 AS ABOVE	POSTCODE: KA48HN
CONTRACT No.			
NAME: MISS GEM MCFARLANE		ADDRESS: A/A	A/A
RELATIONSHIP: PARTNER		DAY PHONE No.	NIGHT PHONE No.
RELIGION: Ch.of Scotland		VISIT REQ. BY CHAPLAIN YES/NO: N	PENSION BOOK No.

Admission

		SPECIAL WARNINGS
DIAGNOSIS		
OTHER CONDITIONS (D.G.2)		
OTHER CONDITIONS (D.G.3)		

SMR50

	PREVIOUS PSYCH. CARE	CONTRIBUTORY SOCIAL FACTOR
...S		

DISCHARGE SUMMARY

	DATE	TIME	DISCH. TYPE	PATIENT CATEGORY	MANAGEMENT OF PATIENT	SPECIALTY	CONSULTANT CODE
	14/10/99					GIM	SAP
RGE ILS	DISCH./TRANSF. TO	READY FOR DISCH.	HOSPITAL: NAME	CODE	WARD	SPECIALTY	CONSULTANT CODE
	SMR04	TYPE OF CARE PROVIDED		ECT - 1st TREATMENT DATE		ECT - NUMBER OF TREATMENTS	

		CODE	SPECIAL WARNINGS
MAIN DIAGNOSIS	Haematemesis	K920	
OTHER CONDITIONS (D.G.2)	Alcohol abuse	F101	
(D.G.3)	Reflux oesophagitis	K210	
(D.G.4)	Erosion of oesophagus	K221	
(D.G.5)	Acute gastric ulcer	K253	
(D.G.6)	Gastritis	K297	

D

		CODE	DATE
MAIN OPERATIONS			
OTHER OPERATION (O.P.2)			
(O.P.3)			
(O.P.4)			

O P E R A T

WRITE, IMPRINT OR ATTACH LABEL

Surname GALLOWAY HCR No.

Forenames STEPHEN Sex

Address D.O.B.

Ward or Dept 3E

346

STA0237

MEDICAL

DATE

10/10/99
2330.

EA via A+E ? haematemesis

HPC. Vomiting yesterday → fresh red blood mouthfuls. Lasted 45 minutes, continued vomiting. Dizzy at time. Since then occasional vomits ? altered blood.
Severe 'heartburn' - for years, worse recently.
Bowels moving normally, colour not seen.
No NSAID
H.O alcohol XS - 1½ bottles vodka 1 day for several months until 3/52 ago. Since then only occ. can of beer.
Prev episode years ago 1x elsewhere, outcome unknown.
Not dizzy / SOB now.

PMH Asthma as child. Prev noted low BP.
Nil else

DH Nil
NKDA

SH Smokes 20 CPD
Alcohol as above

S/E No else findings.

O/E Well No pallor
Apyrexial
HR 60 reg
BP 100/60
HS I+II+0
Chest clear, good AE throughout.
Abdo - paraumbilical tenderness
- soft, BS (+)
- no masses / organomegaly

DATE

Imp Haematemesis prob 2° to gastritis

(P) IV access + fluids
NBM meantime.
Bloods ✓ Hb 14.3 U+E 4.6 Amy 88
G+S WC 11.2 Cr 104 Glc 5.2
Endoscopy - maxe Plt 323 Na 142
Start PPI K 3.7
Cl 104
Bic 80

P M Stto
HULME

11/10/99 09-30 JHAE
Upper GI bleed - probably 2° to alcoholic gastritis. Background of epigastric pain + heartburn over last few weeks
Haemodynamically stable since admission Hb 14.3
→ for upper GI endoscopy.
MS

11/10/99 Results UGIE
- oes: moderate reflux oesophagitis
- stomach - acute gastric ulcer of 0.25cm seen at prepyloric area. Gastritis also noted.
- duodenum - normal.
- H. pylori biopsy ~
- c/o Zantac 300 mg PO od.

Results
Hb 14.2
WCC 11.4
Plt 306

AKahir FRCS (GP 1091)

WRITE, IMPRINT OR ATTACH LABEL

Surname O'Callaghan HCR No.

Forenames Sex

Address D.O.B.

Ward or Dept.

STA0237

MEDICAL

DATE

11/10 Dr Layan

355 pm well

N.B O+A result

this admn

→ Mane ⊕ Esomep

Fe 6/52 for H2 breath test

for PPI for 4/52.

Layan

25/11/99 well.

no Crohn symptoms

- never had Augmentin — admin GP to

give if Crohn symptoms

AS

DATE

CONSENT FOR EXAMINATION

STA1059

XH 468158

Surn GALLOWAY STEPHEN
Fore 41 MAIN ROAD
Add SPRINGSIDE
KA11 3AN
DR.W NICOLL 14/06/1965
Wa 5A HENRIETTA ST
GALSTON
CHI

I Stephen Galloway of 41 Main Rd

Springside hereby consent to

undergo / the submission of my — child / ward

the examination of ENDOSCOPY

the nature and purpose of which have been explained to me by

Dr./~~Mr.~~* ALISON MACRAE

I also consent to such further or alternative operative measures as may be found necessary during the course of the above-mentioned examination and to the administration of general, local or other anaesthetics for any of these purposes.

No assurance has been given to me that the operation will be performed by any particular practitioner. (Not applicable to Section 1 (2) patients.)

Date 11/10/99 Signed S Galloway
(Patient/Parent/Guardian)*

I confirm that I have explained the nature and purpose of this examination to the patient/parent/guardian.*

Date 11/10/99 Signed A Macrae
(Medical/Dental Practitioner)*

*DELETE AS APPROPRIATE

Note: This form is not to be used for any examination where there is a specific consent form with explanations.

Any deletions, insertions or amendments to the form are to be made before the explanation is given and the form submitted for signature.

CONSENT FOR EXAMINATION

CONFIDENTIAL

Form STA0186

THEATRE CHECK SHEET

PART 1 Name, number and ward to be completed by the Medical Secretary when a patient is sent for. The form is then inserted in the Case Sheet. The form then goes to theatre with the Theatre List and the date is filled in and the appropriate theatre indicated.

The sheet will be taken to the ward when the patient is to be collected for operation.

Patient's Name STEVEN GALLOWAY Date of Birth ..... Hospital Number .....

From Ward 3E Date 11/10/99 To Theatre .....

Proposed Operation ENDOSCOPY

PART 11 To be completed by the Ward Sister/Charge Nurse or her deputy and to accompany the patient to theatre, where it should be counter-signed in reception.

CHECKED : Identity Bracelet KP Pre-Medication KP (NONE)

Consent Form(s) KP Removal of Dentures, etc. KP

X-Rays KP Case Record KP

Nursing Notes KP (NONE)

Theatre Blood X Matched Check .....

.....

Signed KP

Ward 3E

Theatre .....

PART 111 Operation .....

.....

Drainage/Packs .....

.....

Post-Op Directions .....

.....

.....

.....

.....

Date .....

Time .....

Signature of Surgeon

North Ayrshire and Arran NHS Trust
Endoscopy Suite

Upper Endoscopy Report

ID Number	468158
Name	Galloway, Stephen
Date of birth	14 Jun 1965 **Sex** Male
Address	41 Main Street Springside
Classification	

Indications
Haematemesis and ulcer type dyspepsia.

Date of procedure
11 Oct 1999 (10:53)

Endoscopist
Dr S Benzie

Assistant
S Simpson
K Linton

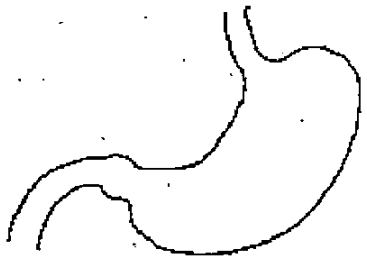
Medications used
No intravenous sedation.
Lignocaine spray.

Instrument
GIF XQ240 No 12

Report
OESOPHAGUS: Moderate reflux oesophagitis (Grade 2: erosions involving <10 % of the distal oesophageal mucosa) was evident. The squamo-columnar mucosal junction (z - line) was at 40 cm.

STOMACH: A 0.25 cm (at greatest width) acute gastric ulcer was found at the prepyloric area. In addition, mild erythematous/exudative gastritis involving the antrum was present.

DUODENUM: The duodenum was normal.



Diagnosis
Reflux Oesophagitis; Grade 2 (530.1)
Gastric Ulcer (531.30)
Gastritis (535.4, 578.9)

Procedures
Biopsy for H. pylori (urease test) Post

Final Disposition
Return to ward. Recommended medication: Lansoprazole 30 mg po mane for 4 weeks.

Dr S Benzie

STA0098 **CROSSHOUSE HOSPITAL - ACCIDENT AND EMERGENCY DEPARTMENT** 2

Triage time 06:40 Triage nurse BLACK Triage group Green

resp rate | sat O2% | PFR

pulse | BP / | GCS

allergy No allergy

BMstix | breath alcohol | temp

urine

VA R L

pain score 97

review score

discharge score

accompanied by Unaccompanied

Triage details

hit on left hand with stick yesterday hand swollen and abrasions to two fingers sutures at base of middle finger which were inserted on Sunday have come out 2/4

treatment

I give consent for details of my injury to be given to the Police

Signed.....

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed:.....Witness.....Witness.....

Surname GALLOWAY
Forename STEPHEN

marital status S
sex M

A/E No. 02019871
Consultant A Lannigan
date/time attendance 15/05/2002 06:23

Date of birth 14/06/1965

age 36

Address 11 CORSE AVE
SPRINGSIDE
AYRSHIRE

alt N

Post code KA113AF

special case

GP JR MAGEE
address CROSSHOUSE CLINIC
GATEHEAD ROAD
CROSSHOUSE
KA2 0HU
phone 01563521506

this problem+total att 7 + 2

phone 213372

incident date/ time OVER 2 DAYS

next of kin GINA FRASER
address SPRINGSIDE

relationship Other
phone

occup
religion Church of Scotland
employer
school

hospital number 468158

disch | A+E clinic | paed tr. | # | eye | ENT | max facial | ward - OP | ward - IP | x-ray? Y / N

(S) 16/5

Drug	Dose	route	time /frequency	signature	given by/quantity
FLUCLOXACILLIN	500mg	oral	QDS		

Time: 0704 **DOCTOR:** GILMORE

36.9 (L) hand injury. (L) nailed.

Old (R) ~~middle~~ ring finger injury - looks infected.

Hit last night ~ 2200h with stick.

Lac over PIPJ (L) middle finger

Smaller abrasions: index + ring finger PIPJs

On defending himself - sutures inserted 12.5.02 by orthopaedics burst

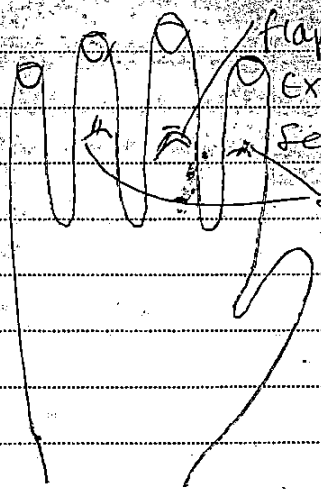
Nailed 12.5 - lac to base ring finger. Loss of sensation referred to ortho - explored

ATT up to date.

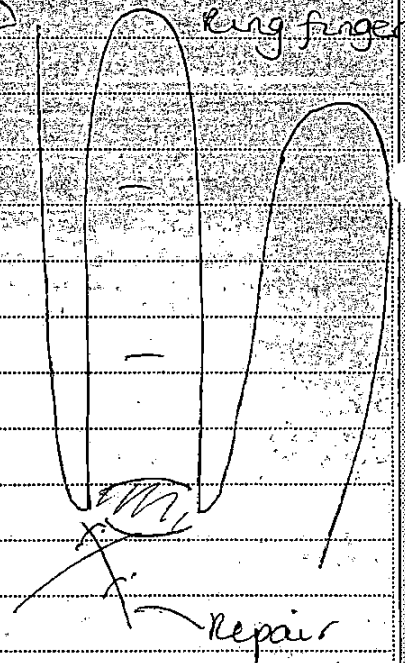
No systemic upset

O/E (L) Apyrexial

dorsum



(L) ring finger



→XR (L) middle finger - NBI / FB.

Wound open

Pus noted - looks infected

No surrounding cellulitis.

~~middle finger~~

Ring block (L) middle finger

Wound toilet - very superficial, no damage to underlying structures

Dry dressing

STEPHEN GALLOWAY. A/E No. 02019871

DATE	CLINICAL NOTES
15·5·02	
	-20 yrs ~10 h old
	-1 Day dressing no suture required
	R ring finger
	wound cleaned
	Evidence of pus → ② Swab
	③ Inadine dressing
	④ Review at A+E clinic today / tomorrow
	⑤ Commence flucloxacillin.
	SHO

STA0098

CROSSHOUSE HOSPITAL - ACCIDENT AND EMERGENCY DEPARTMENT

S/R

Triage time 12:34 Triage nurse MURRAY Triage group Green

resp rate | sat O_2% | PFR

pulse | BP / | GCS

allergy No allergy

BMstix | breath alcohol | temp

urine

VA R L | pain score 97 | review score | discharge score

accompanied by: Unaccompanied

Triage details

drinking last night, claims front lounge window was smashed, cut to inside of right 4th m.c. ring removed, altered sensation to same, normal movement

treatment

Temporary Dressing

2A

I give consent for details of my injury to be given to the Police

Signed.....

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed.....Witness.....Witness.....

Surname GALLOWAY
Forename STEPHEN

marital status
sex M

A/E No. 02019428
Consultant A Lannigan
date/time attendance 12/05/2002 12:24

Date of birth 14/06/1965 age 36

Address 11 CORSE AVENUE
SPRINGSIDE
AYRSHIRE
alt N
Post code KA11 3AF

special case

GP JR MAGEE
address CROSSHOUSE CLINIC
GATEHEAD ROAD
CROSSHOUSE
KA2 0HU
phone 01563521506

this problem+total att 6 + 1

phone 213372

incident: date/ time 18 - 24 hours

next of kin GALLOWAY
address
relationship
phone

occup
religion Church of Scotland
employer
school

hospital number 468158

disch | A+E clinic | paed tr. | # | eye | ENT | max facial | ward - OP | ward IP

x-ray? Y / N

Drug	Dose	route	time /frequency	signature	given by/quantity

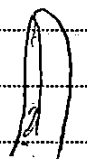
Time: 11-20. DOCTOR: JEYASEEMA VIJAYAKUMAR.

38 yr old male.

PC: Laceration to (R) ring finger since yesterday while on a drinking binge.
Thinks not caused by glass.
Neighbour broke glass, ? ~~her~~ fighting with neighbour

(L) hand dominant

PE: Laceration ~~from~~ base of ring finger. Palmar aspect.
Loss of sensation on the radial aspect of (R) ring finger.



last ate at 10 pm.

→ Referred to Orthopedics.

MEDICAL IN CONFIDENCE

ADMISSION FORM V3

MEDICAL RECOR

HOSPITAL CODE	HOSPITAL NAME	CASE RECORD NUMBER
A111H	CROSSHOUSE HOSPITAL	XHI-468158

DATE	TIME	TYPE	REASON	ADM./TRANS. FROM	INPAT./DAYCASE	DATE ON W.L.	W.L. TYPE	PATIENT CATEGORY
12/05/02	14:43	3	11	11 PR	LA IP			S 3 NHS

WARD	S. FACILITY	SPECIALTY	CONSULTANT	FROM LOCATION	W.G.E.
2A	11	ORTHOPAEDICS	MR G TAIT		0

PATIENT

TITLE SURNAME	FORENAME (1)	(2)	AGE	DATE OF BIRTH	SEX	MARITAL STATUS
MR	GALLOWAY STEPHEN		36	14/06/1965	M	

ADDRESS: 8 CARMEL DR
SPRINGSIDE

ALT./PREV. SURNAME:

OCCUPATION:

C.H.I. NUMBER: 1406650854

POSTCODE: KA11 3AG TELEPHONE No.: 01294 221921 OCCUPATION (HUSBAND/FATHER):

HEALTH BOARD OF RESIDENCE: Ayrshire and Arran HAVE YOU LIVED IN THIS COUNTRY FOR PAST YEAR?

REF. G.P.

NAME: MAGEE R

G.P. CODE: 1352870 PRACTICE: 80166|1

CONTRACT No.: SAC04 FH STATUS: N

ADDRESS: GATEHEAD ROAD CROSSHOUSE

TEL No.: 01563 21506 POSTCODE: KA2 0HU

REF. G.P.

NAME: MAGEE R

G.P. CODE: 1352870 PRACTICE: 80166|1

CONTRACT No.: SAC04 FH STATUS: N

ADDRESS: GATEHEAD ROAD CROSSHOUSE

TEL No.: 01563 21506 POSTCODE: KA2 0HU

NEXT OF KIN

NAME:

RELATIONSHIP:

ADDRESS:

DAY PHONE No.: NIGHT PHONE No.:

MISC.

RELIGION: Ch.of Scotland

VISIT REQ. BY CHAPLAIN YES/NO:

PENSION BOOK No.:

Admission

MAIN DIAGNOSIS

OTHER CONDITIONS (D.G.2)

OTHER CONDITIONS (D.G.3)

SPECIAL WARNINGS

SMR50

	PREVIOUS PSYCH. CARE	CONTRIBUTORY SOCIAL FACTOR
S		

DISCHARGE SUMMARY

DATE	TIME	DISCH. TYPE	PATIENT CATEGORY	MANAGEMENT OF PATIENT	SPECIALTY	CONSULTANT CODE
13 5 02						
DISCH./TRANSF. TO: HOME	READY FOR DISCH.	HOSPITAL: NAME	CODE	WARD	SPECIALTY: ORTHO	CONSULTANT CODE: MR TAIT
SMR04	TYPE OF CARE PROVIDED		ECT - 1st TREATMENT DATE		ECT - NUMBER OF TREATMENTS	

MAIN DIAGNOSIS

OTHER CONDITIONS (D.G.2)

(D.G.3)

(D.G.4)

(D.G.5)

(D.G.6)

SPECIAL WARNINGS

MAIN OPERATIONS	CODE	DATE
OTHER OPERATION (O.P.2)		
(O.P.3)		
(O.P.4)		

WRITE, IMPRINT OR ATTACH LABEL

Surname Wallwork HCR No.

Forenames Stephen Sex M

Address D.O.B. 14/6/65

Ward/Dept. 2A / AE

STA0213

ORTHOPAEDIC

DATE

12/5/92
11.35.

Orders

Intoxicated last night.

No idea of mechanism injury

Now complains of altered sensation + tingling - right ring finger.

- Cubitus the hand.

Able to move finger.

- left-handed painter.

Covered for tetanus

last contact at 10.00am today.

Plan

Admit - post op for xrays.

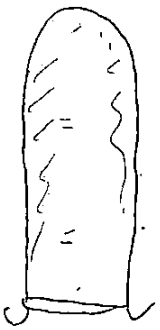
nil else.

On nil

Allergies nil

O/E

Right hand.



Incised wound over base of ring finger

Altered sensation demonstrated

Able to flex finger - No pulling / pain

FDS + FDP clinically intact.

No apparent nicking of finger

DATE

Plan Sheet.
Explanation & LA.
Xmas.

Thanks
30.7.

A&E Num: 02019428

GALLOWAY STEPHEN
11 CORSE AVENUE
SPRINGSIDE
KA11 3AF
Male
14/06/1965
CHI Num:
PAS Num: 468158

WRIT
Surname:.....
Forenames:...
Address;.....
.....
Ward or Dept

CONSENT FOR OPERATION

STA1057

I Stephen Galloway of .....

..... hereby consent to

* undergo / the submission of my

* child / ward .....

the operation of Excision Ring Finger Right Hand

the nature and purpose of which have been explained to me by

Dr./Mr.* Evans

I also consent to such further or alternative operative measures as may be found necessary during the course of the above-mentioned operation and to the administration of general, local or other anaesthetics for any of these purposes.

No assurance has been given to me that the operation will be performed by any particular practitioner. (Not applicable to Section 1 (2) patients.)

Date 12/7/02 Signed .....

(Patient/Parent/Guardian)*

I confirm that I have explained the nature and purpose of this operation to the patient/ parent/guardian.*

Date 12/7/02 Signed .....

(Medical/Dental Practitioner)*

* DELETE AS APPROPRIATE

Note: This form is not to be used for any operation where there is a specific consent form with explantions.

Any deletions, insertions or amendments to the form are to be made before the explantion is given and the form submitted for signature.

CONSENT FOR OPERATION

ACUTE HOSPITALS NHS TRUST

NHS Ayrshire & Arran

THEATRE CARE PLAN

Name STEPHEN GALLOWAY Hospital Number 468158

Ward 2A Date 12/5/02 Theatre 7

Proposed Operation

Pre-Medication

TIME GIVEN

Fasted from: TIME

	WARD			THEATRE		
	YES	NO	N/A	YES	NO	N/A
ɜntification Bracelet				✓		
Consent Form signed				✓		
Operation Site marked					✓	
Waterlow Score						✓
Haemoglobin						✓
Blood X matched						✓
Dentures removed					✓	
Caps/Crowns/Loose teeth: Specify					✓	
Nail Polish/Jewellery/Make-up: Removed					✓	
Rings taped/Body Piercing					✓	
Allergies identified: Specify below					✓	
Pad or Tampon						✓
Catheter in situ						✓
Pre-op Shower						✓
⁻ ⁻n Prep/Shaved: If required						✓
- ⁻per Pants				✓		
ıtient's Stickies included				✓		

Underline above where applicable

Following to accompany patient

Case Notes I/C Drug Kardex				✓		
X Rays/C.T. Scans				✓		
Lab results						✓
E.C.G. if applicable						✓
Pillows extra: Number				✓		
Hearing Aid						✓
Inhalers						✓
Other: Specify						✓

Any other relevant information: (e.g. high risk and allergies)

Ward Nurse *(signature)*

Rec-Recovery Nurse *(signature)*

Anaesthetic Nurse *(signature)* I. McIntyre

ANAESTHETIC CARE GIVEN

Pulse 89 Temp..... BP..... SPo2 96

G.A.	
L.M.A.	
ET TUBE	
FACE MASK	
THROAT PACK	
PACK REMOVED	

SPINAL	
EPIDURAL	
COMBINED SPINAL/EPIDURAL	
LOCAL INFILTRATION	
NERVE BLOCK	
N G TUBE	
Eyes Taped	

Infusion Device

Epidural	
P C A	
T I V A	
Baxter Colleague	
Other	

Invasive Monitoring

C.V.P. I.B.P.

PERI-OPERATIVE CARE

Method of transfer patient

Pat Slide .....

Other: Specify.....

Operation Site confirmed by Scrub Nurse ☐

RIGHT ARM	✓
On board	✓
At side	
Across chest	
Other	
EFT ARM	✓
On board	
At side	✓
Across chest	
Other	

Patient Positioning

Supine	✓
Prone	
Lithotomy	
Trendelenberg	
Rev-Trendelenberg	
Jack Knife	
Right lateral	
Left lateral	
Traction table	
Lloyd Davis	

Diathermy	Application
Bi-polar	Mono-polar
Diathermy	Site
Thigh	
Buttock	
Abdomen	
Other	
Pad correctly applied and checked	

TOURNIQUET

Arm right	✓	Arm left	
Leg right		Leg left	
Digit right		Digit left	
Time on right	20-30	Time on left	
Time off right	20-55	Time off left	

Patient protection safety

Pelvic support i.e. padding	
Lateral support i.e. padding	
Padding bony prominences	
Heel rest	
Head ring	
Prone head ring	
Stirrups	
Pillows	✓
Sand bag	
Other: State	
Warming blanket	
Ripple mattress	
Warm touch	
Thermodrape	
Thermo-hat	
Fluid warmer	
Calf leggings	
Core temp probe	
Other: State	

Evaluation pre-operative

	Yes	No	N/A
Pressure area checked	✓		
Diathermy checked			✓
Tourniquet site checked		✓	

Instrument check pre-op

Named Nurse ..... ROBB .....

Skin Prep solution used .....

Nurse completing care plan peri-op

Signature ..... L. McIntyre .....

Specimens taken: Yes ☐ No ☐ Bacteriology ☐

Pathology ☐ Other ☐ State total in box ☐

Signature nurse receiving specimen from scrub .....

Blood loss measured: Yes ☐ No ☐ Total ☐

Patient catheterised in theatre: Nurse ☐ Doctor ☐ Catheter size ☐ Mls in balloon ☐

Skin closure	Wound drainage
Dressing	Local anaesthetic infiltration

Evaluation post-op	Yes	No	N/A
Pressure areas checked			
Diathermy site checked			
Tourniquet site checked			

Problem needs	Nursing intervention	Outcome

XH 468158

GALLOWAY STEPHEN
41 MAIN ROAD
SPRINGSIDE
KA11 3AN
14/06/1965
DR.W NICOLL
5A HENRIETTA ST
GALSTON
CHI

Theatre 7 Date 12/5/02
Ward 24 Pat. Category 3
Sex: M/F M
Adm. type 3 Adm. date 12/5/02
Consultant TAIT
Speciality ORTHO

Operation type

Reason & time for cancellation e.g <2 hrs

Times	24 hr clock	Reason for delay
Sent for		
Reception		
Anaes. room		
Theatre	20.25	
Recovery		
Out of recovery		

Essential Medical Staff
Surgeon 1 THOMAS
Assistant Surgeon
Anaes. 1 THOMAS
Anaes. 2
Others
Other attendees

Essential Nursing Staff
Room leader ROBB
Anaes. nurse C MCINTYRE
Scrub 1
Auxiliary 1 McMillan

Scrub 2
Circulating 1 McGowan
Circulating 2
Auxiliary 2 Chavez
Others

OPERATION

EXPLORATION WOUND BASE OF RING FINGER - RIGHT

Post-op directions
NIL BY MOUTH TONIGHT THEREAFTER
CLINICAL TASK FOR WOUND REVIEW.

Date 12/5/02 Time 20.50
Signature of Surgeon THOMAS

Anaesthetic type	2.	ASA Grade		Operation classification	1.
Clinical outcome	1.	Destination	1.		

TOM-20-25.

Controlled drugs —

1st Scrub Nurse *(sign)* Circulating Nurse *(sign)* P McGowan
Instrumentation check *(sign)* S Chavez Swab Check P McGowan
2nd Scrub Nurse *(sign)* Circulating Nurse *(sign)*
Instrumentation check *(sign)* Swab Check
3rd Scrub Nurse *(sign)* Circulating Nurse *(sign)*
Instrumentation check *(sign)* Swab Check

Discrepancies documented Yes ☐ No ☐ N/A ☐

Action taken
State where documented

Admission Type
1. Inpatient
2. Day Case
3. A & E Admission
4. Out-patient

Patient Category
1. Amenity
2. Private
3. NHS

Operation Type
1. Elective in hrs.
2. Emergency in hrs.
3. Emergency out hrs.
4. Elective out hrs.
5. Emergency. Weekend/PHs
6. Elective. Weekend/PHs

Reason for Delay
1. Delay with lift
2. Patient not ready
3. Clinical delay
4. Surgeon delayed
5. Anaesthetic delay
6. No Nurse available
7. No Porter available
8. Surgeon req. delay
9. Anaes. req. delay
10. Recovery delay
11. X-ray delay

Anaesthetic Type
1. General
2. Local
3. Epidural
4. Spinal
5. Sedation
6. Plexis/nerve

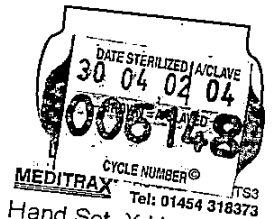
ASA Grade
Insert appropriate code

Op Classification
1. Minor
2. Intermediate
3. Major
4. Super complex

Clinical Outcome
1. Op carried out
2. Op cancelled
3. Op abandoned
4. Alternative op carried out
5. Patient died theatre
6. Patient died recovery
7. ACH baby

Destination
1. Ward
2. ITU
3. HDU
4. Short stay
5. Transfer
6. Other
7. DSU discharge

T.s.s.u instrument stickies



Hand Set X House 06

STEAM
Dark = processed

Orthopaedic
01286080

XP 468158

Surname GALLOWAY STEPHEN
Forenames 41 MAIN ROAD SPRINGSIDE KAITAIA
Address 14/06/1965
DR. NICOLL 5A HENRIETTA ST GISBORNE
Ward or

STA0215

DATE 14/5/02

SURGEON Thomas

ANAESTHETIST LA

ASSISTANT

OPERATION PERFORMED

Exploration of wound base of Rt Index finger

DESCRIPTION OF PROCEDURE 15 ml 0.5% Xylocaine short median nerve block

Pre op. - Infected wound.
- Laceration over palmar radial crease of finger.

- Op. Wound debrided + washed.
- wound extended to form Z.
- Digital nerves explored - found to be intact but bruised.
- Small wound to flexor sheath. - sheath not compromised due to
- Tendons intact.
- Further irrigation of finger.

Wound closed with 3/0 ethilon.

& Tetanol + blue rolls + crepe dressing

DRAINS..... PACKS.....

SPECIAL INSTRUCTIONS TO WARD

FB Mon & Tues with IV Ok

Clinic 14/5/02 pm

Signature Thomas

OPERATION

AMBULANCE SERVICE — PATIENT REPORT FORM

INCIDENT No. 1 0 2 4 9 3 1 8 1

PATIENT NAME: STEPHEN GALLOWAY. SEX: M ☒ F

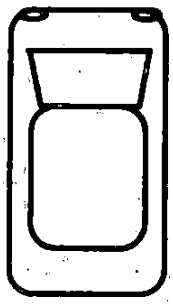
PATIENT ADDRESS: 8 CARMEL DR SPRINGSIDE D.O.B. 1 1 0 6 6 5

TYPE OF INCIDENT

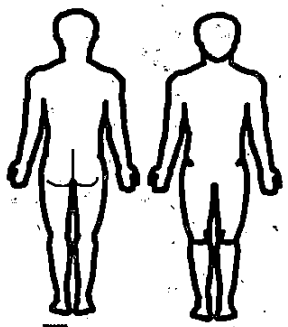
Trauma	
Assault	
Cardiac Arrest	
Other Collapse	
DSH	X
IHT	
Obstetric	
Other	

TRAUMA INCIDENTS

RTA	
Cyclist	
M/Cyclist	
Pedestrian	
Ejected	
Trapped	
>20 mins. Extricate	
Helmet Worn	
Seat Belt Worn	



Home	
Work	
Leisure	
Burns	
Drowning	
Fall < 2 mtr.	
Fall > 2 mtr.	
Head Injury	
Poisoning	
Other	



■ Damaged Area/Burns % # ? Fracture X Laceration

■ Damaged Area ▶ Point of Impact X Position of Patient

INJURY / ILLNESS

Acute Abdo.	
Breathlessness	X
Chest Pain	
Other Cardiac	
Convulsions	
C.V.A.	
DSH O/dose	
Haemorrhage	
Hypoglycaemia	
Other	X

PRIMARY SURVEY

Treatment prior to arrival	Y	N X
By whom		
Duration of treatment / CPR		
Airway	Clear X	Obstructed
Breathing	Y X	N
Circulation - Pulse	Y X	N
D - Alert	Y X	N
Vocal Stimuli	Y X	N
Pain Stimuli	Y X	N
Unresponsive	Y	N X
Vomited	Y X	N
Fitting	Y	N X
Knocked Out	Y	N X

INITIAL ACTIONS

Airway		
Pharyngeal Airway	Y	N
Tracheal Tube	Y	N
Laryngeal Mask	Y	N
Size	•	
Successful ?	Y	N
Breathing		
O2 Flow rate	53 %	6 LTRS
Mask Type	ADULT	
IPPV		
Circulation		Success

Cannulation	Size	Side	Site	Success -full	
1				Y	N
2				Y	N

A.M.P.L.E.

Allergies (See reverse for coding) NONE

1	2	3	4	5	6	7	8	9

Medication: NONE

Past Medical History: GOOD HEALTH

Last Eaten: BREAKFAST

Events Preceding Incident:

OBSERVATIONS

Time	Breathing R.R.	Breathing SpO2 %	Circulation Pulse	Circulation Blood Pressure	Capillary Refill Norm	Capillary Refill Delay	Pupils Left Size (C N D)	Pupils Left React Y/N	Pupils Right Size (C N D)	Pupils Right React Y/N	Glasgow Coma Score E	M	V	Total
1945			110		4		N	4	N	4	4	6	5	15

TREATMENTS

Time	Presenting Condition	Defib. (Joules)	Fluid / Drug	Batch / Box No.	Dose	Route	Result e.g. Pulse,Asys,VF,Other

COMMENTS / ADDITIONAL INFORMATION

PATIENT HAS BEEN DRINKING ALL DAY AND DRANK A BOTTLE OF ZOFLORE 56ML ABOUT 30MINS AGO

(Affix Rhythm Strip Here)

CREW 1	MURPHY	K	SIGNATURE (Crew 1 or 2) K Murphy
CREW 2	NAIRN	B	
MEDICAL STAFF			CONDITION ON ARRIVAL AT HOSPITAL: Conscious X Pulse; Breathing; No Vital Signs
INCIDENT LOCATION	HOME ADDRESS		DESTINATION HOSPITAL: CROSSHOUSE

DATE OF CALL	2 0 0 7 0 4
TIME OF CALL	1 9 3 4
TREATMENT COMMENCED	1 9 3 7
TIME LEFT SCENE	1 9 4 5
TIME ARRIVED HOSPITAL	1 9 5 2

HOSPITAL USE ONLY

Zoflora (Floral Disinfectant)

Ingredients:

Methylated spirits
Cetrimide
Plus 5 other ingredients

Toxicity:

Low. Fatal dose of this product is a few hundred mls.

Methylated spirits - features and management

Features:

Are mainly due to the ethanol content with burning of the mouth and throat, dizziness, dysarthria, ataxia and drowsiness.

If large quantities are ingested coma may develop with hypotonia, hyporeflexia and respiratory depression.

Though methylated spirits contain about 5% methanol the risk of optic nerve damage is remote unless large amounts have been consumed.

Management:

SUPPORTIVE

1. Gastric lavage is unlikely to be of benefit.

2. Give liberal fluids.

3. If consciousness is impaired protect the airway and ensure adequate ventilation.

4. Forced diuresis, intravenous fructose and dialysis should not be used.

End

STA0098

CROSSHOUSE HOSPITAL - ACCIDENT AND EMERGENCY DEPARTMENT

Triage time 19:56 | Triage nurse | Triage group Orange

resp rate	14	sat O2%	98
PFR			
pulse	90	BP	149/79
GCS	5		
allergy	No allergy		
BMstix		breath alcohol	
temp			
urine			
VA	R L		
pain score			
accompanied by:	Partner	review score	
discharge score			

Triage details

treatment

ADMIT 5A

I give consent for details of my injury to be given to the Police

Signed.....

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed.....Witness.....Witness.....

Surname	GALLOWAY
Forename	STEPHEN
marital status	S
sex	M
A/E No.	01029767
Consultant	A Lannigan
date/time attendance	21/07/2001 19:51
Date of birth	14/06/1965
age	36

Address: 8 CARMEL DR
SPRINGSIDE
IRVINE
AYRSHIRE

alt N

Post code: KA11 3AG

special case

this problem+total att: 3 + 1

GP: A ADRAIN
address: CROSSHOUSE CLINIC
GATEHEAD ROAD
CROSSHOUSE

KA2 0HU

phone: 1563521506

phone: 07944 938174

incident: date/ time: < 6 hours

next of kin: JEM MCFARLANE
address: 8 CARMEL DR
SPRINGSIDE
IRVINE
AYRSHI
KA11 3AG
relationship: Partner
phone: NIL

occup
religion: Church of Scotland
employer
school

hospital number

disch | A+E clinic | paed tr. | # | eye | ENT | max facial | ward - OP | ward - IP

x-ray? Y / N

Drug	Dose	route	time /frequency	signature	given by/quantity
Hydrocortisone	200mg	IV	20.20		

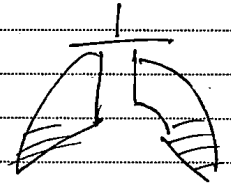
Time: 20.05 **DOCTOR:** ARMSTRONG

36yo ♂ - Drinking heavily all day.
Drank 56 ml bottle of "Sofora" disinfectant.
Prev. DSH attempts.
Prev. attended Dykebar Hosp.
Meds - Nil
NKDA
PMH
Depression
DSH.

GCE Intoxicated. GCS 15. Moves all 4 limbs. Emotional.

A - Stable. Talking.
No drooling.
"Gripping throat".

B - Spontan. Sats 98%.



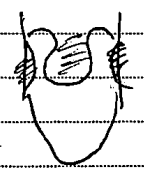
Exp. wheeze bilat.
RR 16

C - HR 70bpm
BS 16/40
BP 169/79.

CXR
NAD. seen.

D - GCS 15. Moves all 4 limbs.

E - Blood on tongue.



Throat - red & slightly inflamed. Pt. chokes coughs

Plan - Bloods - - Hydrocortis
- Encourage Oral fluid & Milk - - IV Fluids -

MEDICAL IN CONFIDENCE

ADMISSION FORM V3

MEDICAL RECORD

HOSPITAL CODE	HOSPITAL NAME	CASE RECORD NUMBER
A111H	CROSSHOUSE HOSPITAL	XHI-468158

DATE	TIME	TYPE	REASON	ADM./TRANS. FROM	INPAT./DAYCASE	DATE ON W.L.	W.L. TYPE	PATIENT CATEGORY
21/07/01	20	29	36	11 10 PRNAD	IP			8 3 NHS

WARD	S. FACILITY	SPECIALTY	CONSULTANT	FROM LOCATION	W.G.E.
5A		11 EAR, NOSE &	THROAMR P WARDROP		0

PATIENT

TITLE SURNAME	FORENAME (1)	(2)	AGE	DATE OF BIRTH	SEX	MARITAL STATUS
MR	GALLOWAY STEPHEN		36	14/06/1965	M	

ADDRESS: 8 CARMEL DR
SPRINGSIDE

ALT./PREV. SURNAME:

OCCUPATION:

C.H.I. NUMBER: 1406650854

POSTCODE: KA11 3AG TELEPHONE No.: 01294 221921 OCCUPATION (HUSBAND/FATHER):

HEALTH BOARD OF RESIDENCE: Ayrshire and Arran HAVE YOU LIVED IN THIS COUNTRY FOR PAST YEAR?

REF. G.P.

NAME: MAGEE
G.P. CODE: 1352870 PRACTICE: 80166 1
CONTRACT No.: SAC04 FH STATUS: N

ADDRESS: R GATEHEAD ROAD CROSSHOUSE
TEL No.: 01563 21506 POSTCODE: KA2 0HU

REF. G.P.

NAME: MAGEE
G.P. CODE: 1352870 PRACTICE: 80166 1
CONTRACT No.: SAC04 FH STATUS: N

ADDRESS: R GATEHEAD ROAD CROSSHOUSE
TEL No.: 01563 21506 POSTCODE: KA2 0HU
AS ABOVE

NEXT OF KIN

NAME: MS JEM MCFARLANE
RELATIONSHIP: PARTNER

ADDRESS: AS ABOVE
DAY PHONE No.: NIGHT PHONE No.:

MISC.

RELIGION: Ch.of Scotland

VISIT REQ. BY CHAPLAIN YES/NO: N

PENSION BOOK No.:

Admission

MAIN DIAGNOSIS							SPECIAL WARNINGS
OTHER CONDITIONS (D.G.2)							
OTHER CONDITIONS (D.G.3)							

SMR04 SMR50

IS	PREVIOUS PSYCH. CARE	CONTRIBUTORY SOCIAL FACTOR

DISCHARGE SUMMARY

1/60

DATE	TIME	DISCH. TYPE	PATIENT CATEGORY	MANAGEMENT OF PATIENT	SPECIALTY	CONSULTANT CODE
21/7/01					EWT	M Wardrop

DISCH./TRANSF. TO	READY FOR DISCH.	HOSPITAL: NAME	CODE	WARD	SPECIALTY	CONSULTANT CODE
Home						

SMR04	TYPE OF CARE PROVIDED		ECT - 1st TREATMENT DATE		ECT - NUMBER OF TREATMENTS	

MAIN DIAGNOSIS							SPECIAL WARNINGS
OTHER CONDITIONS (D.G.2)							
(D.G.3)							
(D.G.4)							
(D.G.5)							
(D.G.6)							

	CODE	DATE
MAIN OPERATIONS		
OTHER OPERATION (O.P.2)		
(O.P.3)		
(O.P.4)		

WRITE, IMPRINT OR ATTACH LABEL

Surname Galloway HCR No.

Forenames Stephen Sex

Address D.O.B 14/6/65

Ward or Dept

STA0149

DATE

21/7/01
2100h

OLIVER
36 y ♂
Intoxicated + depressed
Drank 50ml Floral Disinfectant ~ 6pm
vomited tt since
No Stridor / respiratory distress
Throat + mouth painful
V- tearful + upset
- marital problems
- currently at home looking after 8/12 son

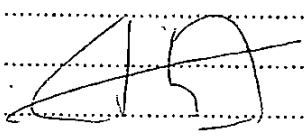
Asthma as child
Peptic ulcers

No meds
NKA

Hx depression + self-harm

States he will not attempt to harm himself but says he still wishes 'at times that he was dead'
- very intoxicated + emotional.
- agrees to stay for observ^n + assessment.

OE well, intoxicated
Alert + orientated GCS 15
Hoarse speech but tearful



Bilat AE L=C = +++
No wheeze / creps
CVS - NAD
HS 1 ± 1 ± 0 added
Abdo NAD.
Mouth - superficial mild erosions
- no airway compromise
- unable to examine larynx

OTOLARYNGOLOGY

DATE

CNS grossly intact

Poisons Bureau:
memated spirits
low toxicity
Rx = fluids

Plan @ N e oral fluids
② Observe closely
③ Review in am ± nasal endoscope
④ Psychiatry referral in am.

U 4.7	Cl 103	Hb 140
Cr 95	Bic 21 b	WCC 10.5
Na 142	GLU 4.9	Plt 308
K 3.9	GLBOH 241	

Coag N

21/7/10 2130 Nurse
Pt refuses to stay in hospital
says 'it was a phase & now it's passed'
feels better & less tearful
A bit embarrassed.
Discuss sto on call
- not detainable
- encourage him to seek help via GP
Pt agrees to this
Signed D.A.M.A. form witnesses - N. Murphy
A - Oliver
Left ward @ 2145
GP letter ✓

WRITE, IMPRINT OR ATTACH LABEL

Surname... XH 468158
Forename GALLOWAY STEPHEN
Address 8 CARMEL DR
SPRINGSIDE
KA11 3AG

STA0213

Ward/D DR.J MAGEE 14/06/1965
GATEHEAD ROAD CROSSHOUSE

DATE

MR TAIT'S ORTHOPAEDIC CLINIC
27 05 02 BT /AR Stephen Galloway 468158
cc Dr Adrain Gatehead Rd Crosshouse
This gentleman returned for review following a wound infection. The erythema associated with cellulitis has settled on his antibiotics. The wound itself is a little sloughy, however, the surrounding tissue is healthy. It has been cleaned today, re-dressed and we will see him back in one week's time.

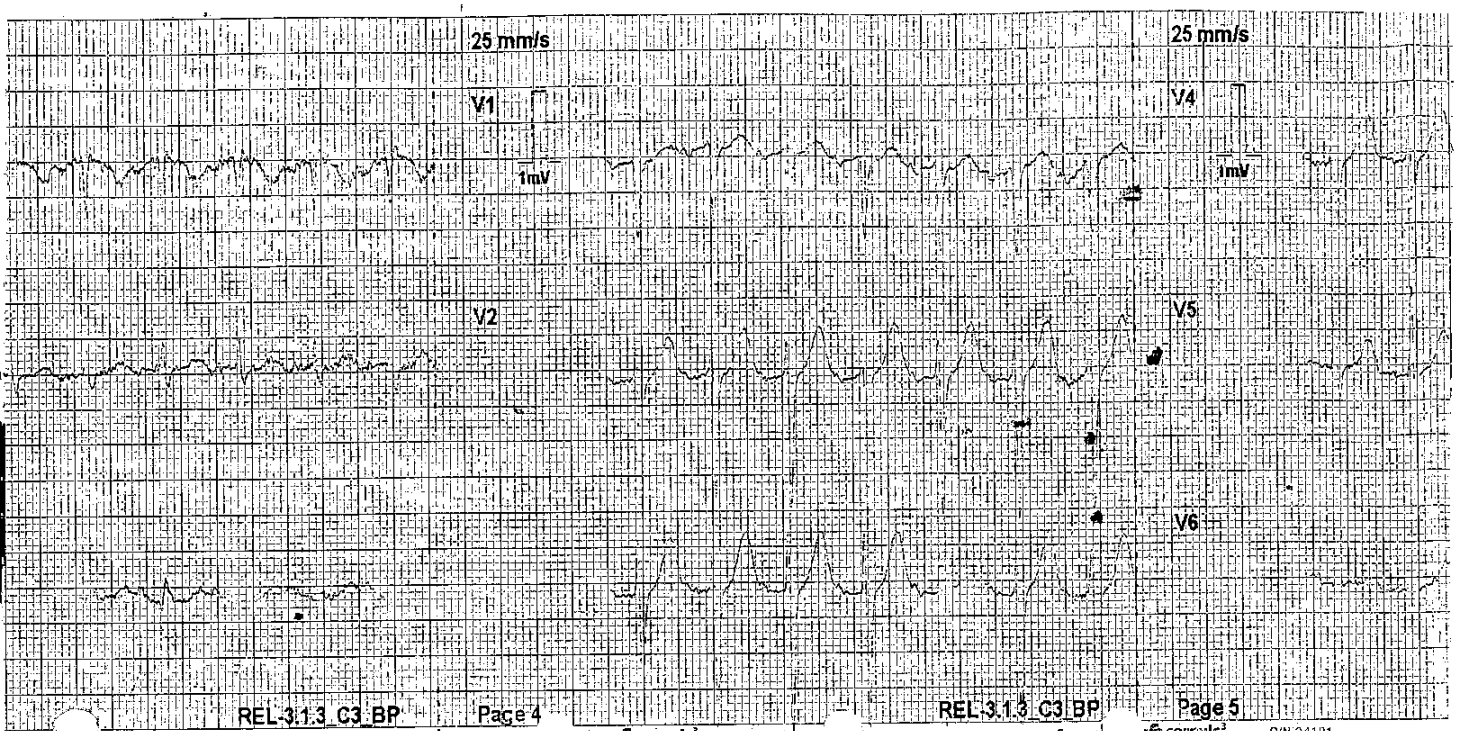
MR FITZGERALD'S FRACTURE CLINIC
03.06.02 BT/LB STEPHEN GALLOWAY 468158

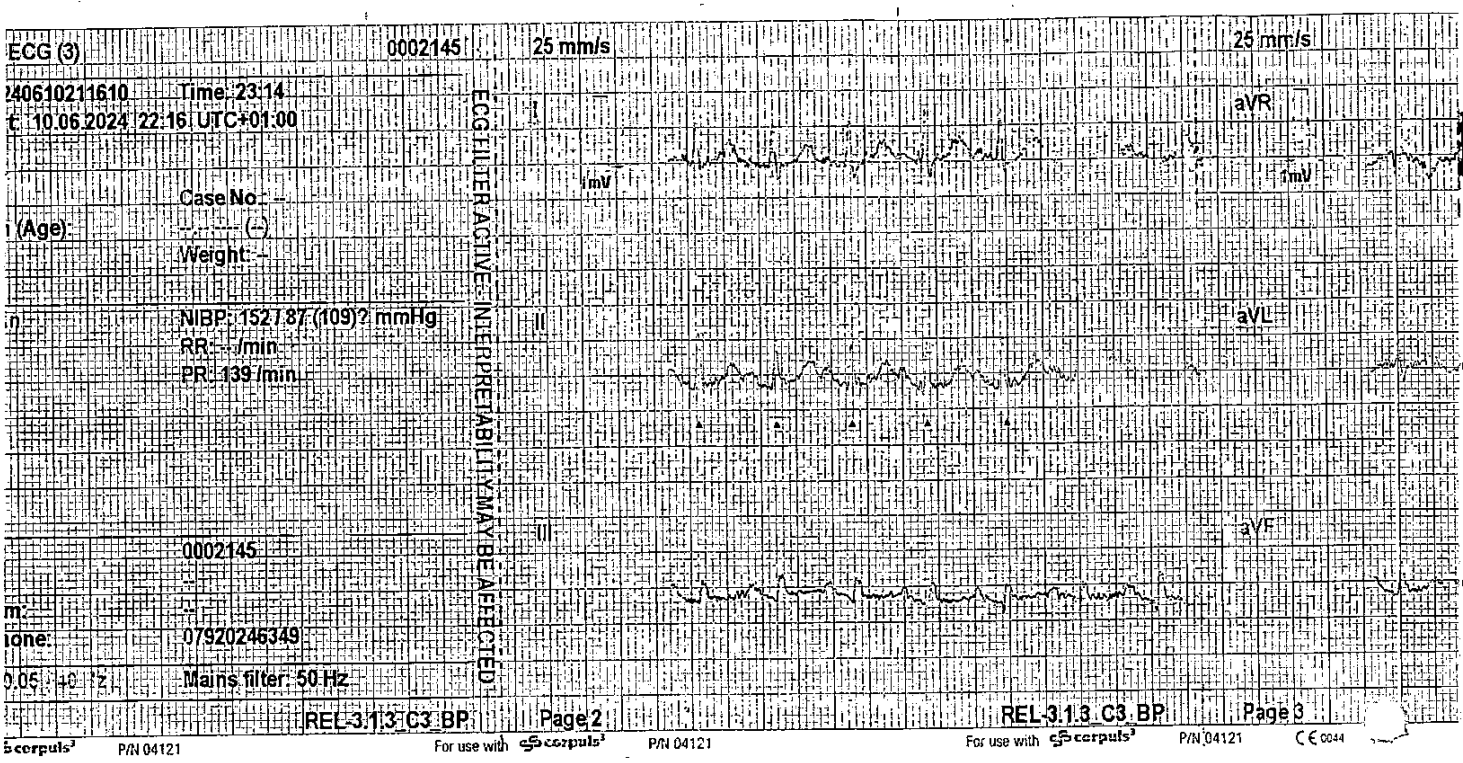
This gentleman was due to return for review of the wound at the base of his right ring finger. He has failed to attend today and he has not been given a further appointment.

The wound was looking healthy at the last visit.

C.C. **Dr Magee, Gatehead Road, CROSSHOUSE**

ORTHOPAEDIC


25 mm/s
V1
1mV
V2
25 mm/s
V4
1mV
V5
V6


ECG (3)
0002145
25 mm/s
25 mm/s
240610211610
Time: 23:14
10.06.2024 22:16 UTC+01:00
aVR
1mV
Case No: --
(Age):
(--)
Weight: --
NIBP: 152?87 (109)? mmHg
RR: --/min
PR: 139 /min
aVL
ECG FILTER ACTIVE - INTERPRETABILITY MAY BE AFFECTED
II
aVF
0002145
07920246349
Mains filter: 50 Hz
REL-3.1.3_C3_BP
Page 2
REL-3.1.3_C3_BP
Page 3
cerpuls³
P/N 04121
For use with cerpuls³
P/N 04121
For use with cerpuls³
P/N 04121
CE 0044

GE Healthcare

Galloway, Stephen
Male
14.06.1965 (58 Years)

Vent. rate	110
PR interval	[illegible]
QRS duration	[illegible]
QT/QTc-Baz	342/462 ms
P-R-T axes	76 37 53

Patient ID: 1406650854
Sinus tachycardia
Otherwise normal ECG

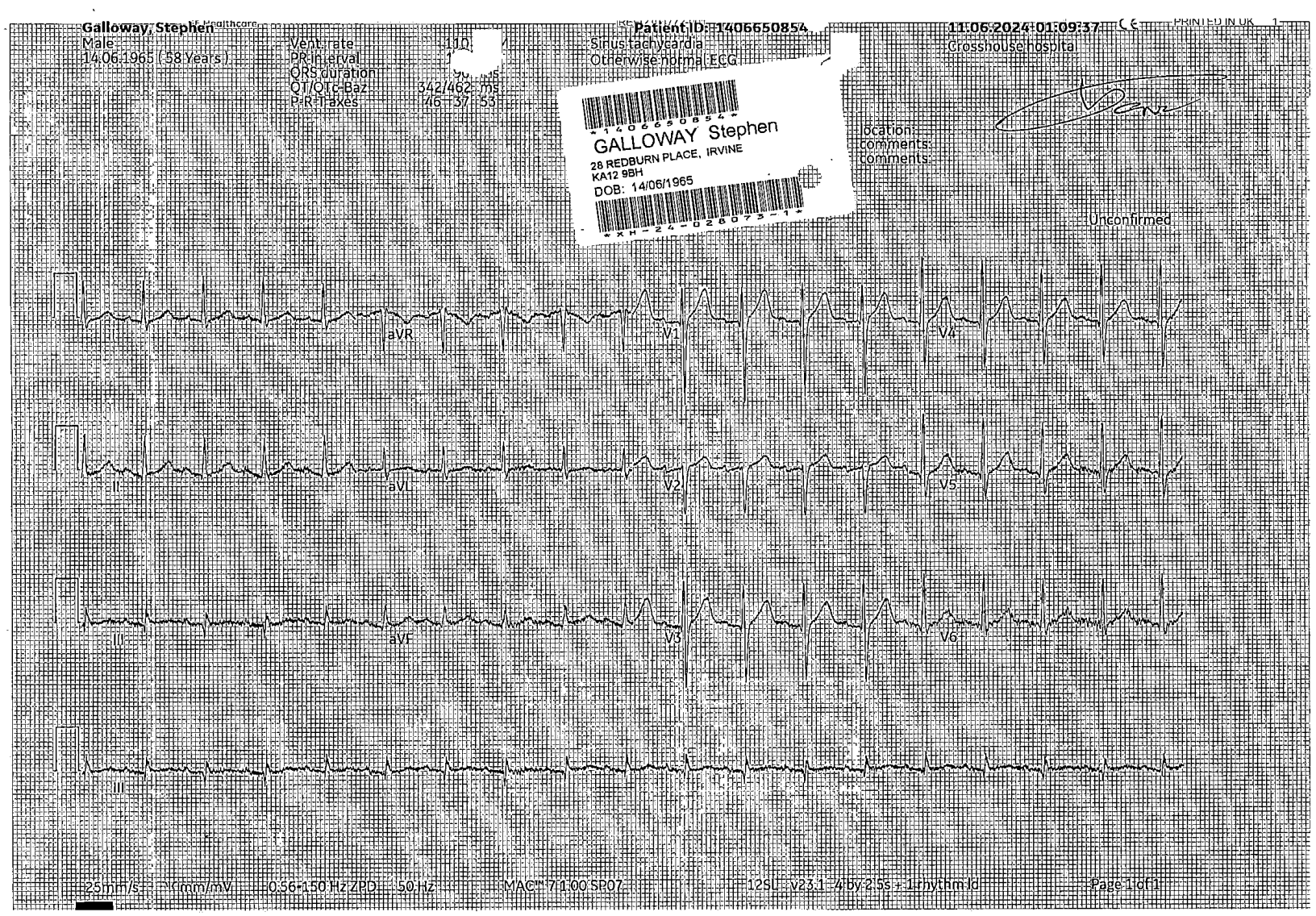
GALLOWAY Stephen
28 REDBURN PLACE, IRVINE
KA12 9BH
DOB: 14/06/1965

11.06.2024 01:09:37

Grosshouse hospital

location:
comments:
comments:

Unconfirmed



25mm/s 10mm/mV 0.56-150 Hz ZPD 50 Hz MAC™ 7 1.00 SP07 12SL v23.1 4 by 2.5s + 1 rhythm ld

NHS Ayrshire & Arran, General Hospitals Division

GASTROSCOPY REPORT

Name: **Stephen GALLOWAY (M)**
Date of birth: **14/06/1965**
CHI No: **1406650854**
Case note no.: **1406650854**

Address: **28 Redburn Place**
Irvine
Ayrshire
KA12 9BH

GP: **Dr T Miller**
Frew Terrace Surgery
9 Frew Terrace
Irvine
Ayrshire
KA12 9DY

Procedure date: **19th May 2021 (15:44)**
Priority: **Urgent**
Status: **Outpatient/NHS**
Hospital: **Crosshouse Hospital**
Referring Cons: **Dr S Smith**

Indications
Melaena.

Report
The scope was retroflexed in the stomach.
The procedure was completed successfully to D2.
Apparent mucosal junction at 38cm from the incisors.

Site a: An area extending from the upper body to the lower body
Gastritis: mild erythematous/exudative with no bleeding.

Diagnosis
OESOPHAGUS. Normal.
STOMACH. Non-erosive gastritis.
DUODENUM. Normal.

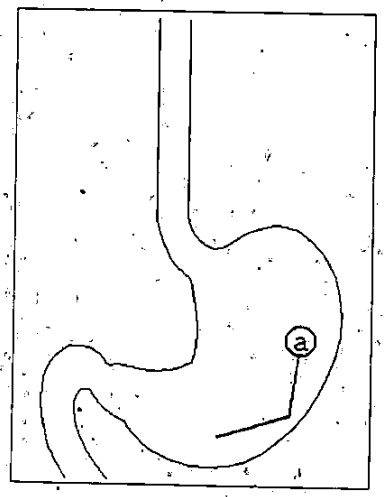
Advice/comments
Mild gastritis- no gastroenterology follow up required currently.

Follow up
Return to the referring doctor.

Consultant/Endoscopist
List consultant: Dr A S Taha
Endoscopist No1: Dr J Orpen-Palmer
Nurses: S/N T Dallas
S/N T Nimbley

Instrument
1 XH GIF Q260 2856685

Premedication
Lignocaine Spray (Oral) 100 mg



a: *An area extending from the upper body to the lower body*

Dr David Watkin
Consultant Physician in Acute Medicine
GMC 6075927 Page 3398

RECEIVED
20 MAY 2021

Dr J Orpen-Palmer
ST4

Gastro consultant - AST 19/5/21 - ENDO

CHI: 1406650854 **Name:** Stephen Galloway **Gender:** Male **DOB:** 14/06/1965 **Age:** 55 Yrs **Phone:** 07468337186

Diagnostic OGD OP

19/5 @ 14.20

Order Details

Diagnostic OGD OP

Change Item

Test Visit No

Status: Requested (Requested)

Receiving Location: Crosshouse Endoscopy C

Priority: Is required after discharge (urgent)

Start Date/Time: 16/12/2020

Start Time: 18:56

Requested By: Angela Stroyan

Texti

Patient Location when Ordered: CAU XH Ambulatory Car

Questions and Answers

Scanned Documents

Annotate

Images

nu7275 nu7275

Clinical Questions and Answers

Clinical Indications: What clinical questions should this exam answer? (Please detail reason for this procedure and when this procedure should be completed) **Was IP, alxs and stopped abruptly, ETOH withdrawal, maleana and dark urine. Discharged after no more episodes of malaena and Hb improved. ?UGI/varicies.**

Relevant past medical history / Significant Major / Co-Morbidities / Respiratory or Neuromuscular Disorder **alxs**

copd

GI bleed

MI

anxiety/depression

List to be booked on (please state in Other box if specific consultant) : **Pooled List**

Is the patient Diabetic? **No**

Does this patient have a pacemaker? **No**

Is this patient on Anticoagulants, if so please state the following mandatory requirements: Which drug? Indication? If drug can be stopped and if this patient will require 'Bridging' **No**

Is this patient on Anti-platelets, if so please state the following mandatory requirements: Which drug? Indication? If drug can be stopped and if this patient will require 'Bridging' **No**

Does this patient have allergies? **nil**

Other Comments? (e.g. Translator Required? Which Language?)

Is this a repeat procedure? **No**

Processing Notes

Responsible Clinician: Dr Stacy Smith

User: ms5106

Audit Trail

Update

Alert Messages Alert Messages

Consent form

Patient agreement to endoscopic investigation or treatment

Patient details

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

Name of procedure(s)

Endoscopy (gastroscopy/oesophago-gastro duodenoscopy)

Inspection of the upper gastrointestinal tract with a flexible endoscope (with or without biopsy and photography).

Biopsy specimens will be retained.

atement of patient

ou have the right to change your mind at any time, including after you have signed this form.

I have read and understood the information in the attached booklet including the benefits and any risks.

I agree to the procedure described in this booklet and on the form..

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

Where a trainee performs this examination, this will be carried out under supervision by a fully qualified practitioner.

I would like to have: **local anaesthestic throat spray** ☑ **or sedation** ☐
(please tick box)

Signed _____ **Date** 18/5/21

me (print in capitals) STEVIE GALLOWAY

.. you would like to ask further questions please do not sign the form now. Bring it with you and you can sign it after you have talked to the health care professional.

Confirmation of consent
(to be completed by a health care professional when the patient is admitted for the procedure).

I have confirmed that the patient/parent understands what the procedure involves including the benefits and any risks.

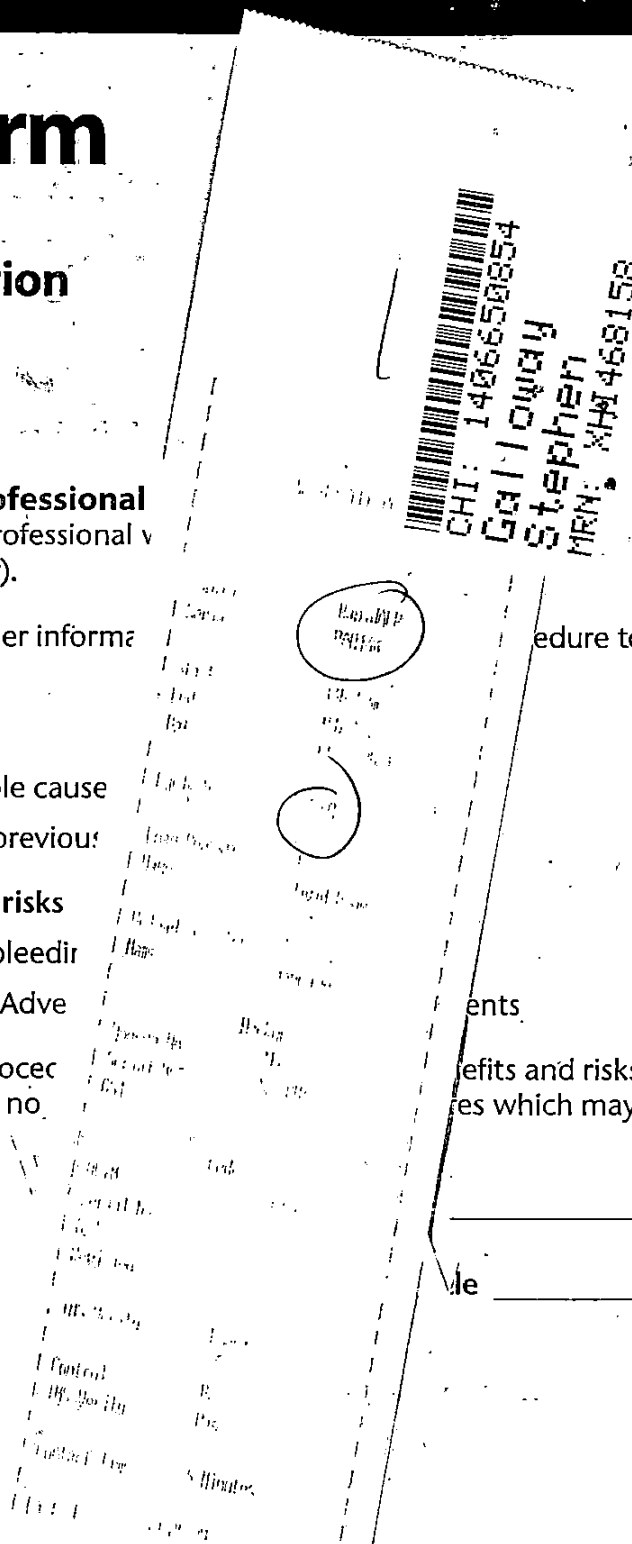
I have confirmed that the patient/parent has no further questions and wishes the procedure to go ahead.

Signed C Roberts **Date** 19/5/2021.

Name (print in capitals) C Roberts **Job title** _____

Consent form

Patient agreement to endoscopic investigation or treatment



Statement of health care professional
(to be filled in by a health care professional v ...sed procedure, as specified in the consent policy).

In response to a request for further informa ...edure to the patient. In particular, I have explained:

The intended benefits

- To diagnose and treat a possible cause
- To review the findings of any previou:

Serious or frequently occurring risks

- Endoscopy risks: Perforation, bleedi
- Sedation or throat spray risks: Adve ...ents

I have also discussed what the proced ...efits and risks of any available alternative treatments (including no ...es which may become necessary and any particular c

Signed _____ _____

Name (print in capitals) _____ ...le _____

Statement of interpreter
(where appropriate)

I have interpreted the information above to the patient/parent to the best of my ability and in a way in which I believe they can understand.

Signed _____ Date _____

Name (print in capitals) _____

NHS Ayrshire

NHS Ayrshire & Arran, General Hospitals Division

GASTROSCOPY REPORT

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Date of birth: **14/06/1965**
CHI No: **1406650854**
Case note no.: **1406650854**

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Ayrshire
KA12 9BH

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Ayrshire
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Diagnosis
OESOPHAGUS. Normal.
STOMACH. Non-erosive gastritis.
DUODENUM. Normal.

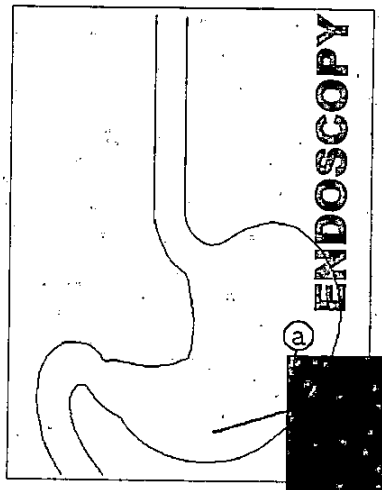
Advice/comments
Mild gastritis- no gastroenterology follow up required currently.

Follow up
Return to the referring doctor.

Consultant/Endos
List consultant: Dr A
Endoscopist No1: Dr J Orpe
Nurses: S/N
S/N T

Instrument
1 XH GIF Q260 285[illegible]85

Premedication
Lignocaine Spray (Oral) 10[illegible]mg



a: *An area extending from t*
upper body to the lower

Dr J Orpen-Palmer
GT4

HAEMATOLOGY

STA0261

NHS Ayrshire & Arran

Area Laboratory: Haematology

GALLOWAY,STEPHEN
28 REDBURN PLACE

IRVINE
KA12 9BH

CHI No. 1406650854
Unit No.
DOB 14/06/1965
Sex M.

Clinician: Dr Gethin R Williams
Request Location: CAU Crosshouse

DSU

TAHA

This report to : Dr Gethin R Williams , CAU Crosshouse

	Result	Units	Normal Range

NHS Ayrshire & Arran

Area Laboratory Blood Transfusion

Surname GALLOWAY
Forename STEPHEN
DoB 14/06/1965
Age / 55 Sex M

CHI No 1406650854
Hosp No
Cons Unknown Clinician
Location XH Hosp. A&E Dept.

Lab No 20X351110
Sample Date 13/12/20 01:00

RMB

11

allbo important

Blood Group O Rh D POSITIVE

14 DEC 2020

Antibody Report NO ATYPICAL RED CELL ANTIBODIES DETECTED
Please note this is a First Time Sample.
In the event that red blood cells or other blood components are required a second sample will be required by Blood Bank.
This will not affect URGENT requests.

EMERGENCY DEPARTMENT	
No Action	
Inform GP	
Inform Ward	
Phone Cancer Tracker	
Signature	

STA5717

ory

S

STA5717

tory

Request Entered 13/12/20 02:14 Date Reported 13/12/20 10:40 Authorised by Heather Daniels

If you have received this report in error, please return to the Blood Transfusion Laboratory

STA5718

Printed

If you have received this report in error, please return to the Haematology Laboratory

Lab No 18B371969 Date Collected 15/08/18 10:00 Authorised By Karen Willis
Printed 15/08/18 14:23 Sample Type Blood Page 1 of 1

If you have received this report in error, please return to the Haematology Laboratory

u have received this report in error, please return to the Haematology Laboratory

ou have received this report in error, please return to the Haematology Laboratory

If you have received this report in error, please return to the Haematology Laboratory

GALLOWAY, Stephen *Born* 14-Jun-1965 (59y) *Sex* Male *CHI No.* 1406650854

Address 28 Redburn Place, Irvine, AYRSHIRE	*Phone and email*	Allergies not recorded

Usual Address
28 Redburn Place
Irvine
AYRSHIRE

Not known

GALLOWAY, STEPHEN *Born* **14-Jun-1965 (59y)** *Sex* **Male** *CHI no* **1406650854**

Address **28 Redburn Place, Irvine, AYRSHIRE** *Allergies not recorded*

Header

Report XR Chest

Report ID AA15102979901	**Discipline** Radiology
Import Date 19/06/2024 07:21:10	**Location** 80698
Report Date 19/06/2024 07:18	**Requested For** Mohyudin Dingle (ST6)

XR Chest

Investigation Status
Local Code : F

Dr Gordon McK...sh
GMC No. 7421162

Radiology Report

Patient Name: Stephen Galloway
DOB: 14/06/1965
Patient ID: 1406650854
Examination Dated: 11/06/2024 03:14

Reported: 19/06/2024 07:16
Exam: XR Chest Accession: AA15102979901

Findings:
Normal cardiomediastinal contours. No acute lung or pleural pathology demonstrated. No destructive bone lesion.

Conclusion:
As above

4Ways Reporting Radiologist: Ali Zaman - GMC 7041028 on 19/06/2024 07:16
Findings

Reported by: 4Ways Reporter

Investigation Performed
11/06/2024 03:14

Investigation Reported
19/06/2024 07:18

Investigation Verified

GALLOWAY, STEPHEN *Born* **14-Jun-1965 (59y)** *Sex* **Male** *CHI no* **1406650854**

Address **28 Redburn Place, Irvine, AYRSHIRE**

Allergies not recorded

19/06/2024 07:16

Diagnostic Service Section code
Local Code : 008

Investigation ID By Provider AA15102979901

WARNING: Textual results that are too long for the width of the printed page will be word wrapped which may disrupt any original formatting. It is suggested to print structured textual results on a landscape layout. The result may have been amended or updated since printing took place so please check Review.

University Hospital Crosshouse
Medical Imaging Department
Kilmarnock Road
Crosshouse
KA2 OBE

30

NHS Ayrshire & Arran

Diagnostic Imaging Report

CHI No.	: 1406650854	Referrer Clinician	: Gordon Maxwell (Cons)
Patient Name	: Galloway, Stephen	Specialty	: Acute Medicine
Patient Address	: 28 Redburn Place Irvine AYRSHIRE KA12 9BH	Address	: Site: Ayr Hospital Room ID: CAU Office Ext: 16247
DOB	: 14/06/1965	Ward/Clinic	: XH CAU Pre-Arrivals
Gender	: Male	Attendance No.	: 50788484

Examination(s): **XR Chest** — Exam Date : **13 October 2023**

Accession(s) : **AA15078848401** — Report Date : **17 October 2023**

Authorised

Patient Name: Stephen, Galloway
Patient Address: 28 Redburn Place, KA12 9BH
DOB: 14/06/1965
Patient ID: 1406650854
Accession Number: AA15078848401
Referring Cons: Gordon Maxwell (Cons)
Referring Dept: XH CAU Pre-Arrivals
Site: University Hospital Crosshouse

50788484 13/10/2023 XR Chest

Clinical Indications
Pleuritic chest pain with chest wall tenderness ?PTX

Report

No significant interval change when compared to previous x-ray dated 06/10/2021.

No pneumothorax or pleural effusions.

Cardiomediastinal contours are within normal limits. The lungs are clear; no collapse or consolidation. Longstanding elevation of the left hemidiaphragm. Visualised bony thorax appears intact.

Hewitt, Lorna (Reporting Radiographer, RA71218)

[END REPORT]

Reported by	Hewitt, Lorna (Reporting Radiographer, RA71218)
Authorised by	Hewitt, Lorna (Reporting Radiographer, RA71218)

Radiology Results displayed are **verified reports only**

DEPARTMENT OF RADIOLOGY

Name: **Stephen GALLOWAY** D.o.B: **14/06/1965** Sex: **M** CHI No.: **1406650854**
Patient ID: **1406650854**
Address: **28 Redburn Place, , , Irvine, KA12 9BH** Attendance Number: **AA13885531201** Sample Site: **Radiology**
Requester: **()** Location: **BLANK**
Examination Date: **13/12/2020 02:26**
Authorised by:

Examination: General **Auth. Date:** 22/12/2020 12:35

: 13 December 2020, 02:26:00
: 13 December 2020, 02:27:00

: RADIOLOGY REPORT
: CHI NUMBER: 1406650854 Examination Number: 38855312 Examination Date: 13/12/2020
: Name: Galloway, Stephen DOB: 14/06/1965
: Address: 28 Redburn Place, , Irvine, KA12 9BH -- CC: -
: Referring Department / Location: Accident & Emergency
: Crosshouse Hospital
: Kilmarnock Road
: Crosshouse
: Ayrshire
: KA2 0BE
: Referring Consultant: Dr E McKenzie Clinical Specialty: Accident & Emergency
: Date Dictated: 21/12/2020 Typed by: None
: Examination: XR Chest

: Clinical Indication

: fall on stairs. left chest wall pain ?fracture ?pul contusion

: Report:
: Compared to previous chest radiographs most recently dated 9/4/2019.
: Normal cardiomediastinal outline. Lungs are clear. There is elevation of the left hemidiaphragm, this is of longstanding and is present on radiographs dating back to 21/1/2019. No bony abnormality.

: Dictating Radiologist / Clinical Specialist Halafihi, Gillian (ST4 Reg)

: Signed by: Halafihi, Gillian (ST4 Reg)
: Verified by: Dr D B Sarkar (Cons Radiologist)
Reported By: Gillian (ST4 Reg) Halafihi
Released By: Dr D B Sarkar (Cons Radiologist)
Released On: 22/12/2020 12:35

RADIOLOGY REPORT

CT Head

Patient ID	1406650854:OHCP	**Patient Name**	GALLOWAY, Stephen
Sex	Male	**Date Of Birth**	14-Jun-1965
Performed	10-Dec-2024 22:13	**Order Number**	AA15119431001
Ordering Provider	Dingle (ST6)	**Status**	Final

General

Final

:
:
:
: Patient Name: Stephen, Galloway
: Patient Address: 28 Redburn Place, KA12 9BH
: DOB: 14/06/1965
: Patient ID: 1406650854
: Accession Number: AA15119431001
: Referring Cons: Mohyudin Dingle (Cons)
: Referring Dept: XH ED
: Visit Type: A\T\E
: Site: University Hospital Crosshouse
:
:
: 51194310 10/12/2024 CT Head
: –
:
:
: Clinical Indications
: Intoxicated head injury and fall, possible LOC, GCS 14/15 due to confusion. ?evidence of bleed
:
: Report
: Date of exam: 10/12/2024
: Date of Report: 10/12/2024
:
: Clinical details:
:
: Findings: CT head
: Normal ventricular system and CSF spaces.
: No areas of parenchymal contusion or surface haematoma.
: There is a background of deep white matter ischaemia but no areas of acute infarction.
: No space-occupying lesion.
: Left frontal scalp haematoma noted.
: No fractures of the calvarium or skull base.
: Osteoma in the right anterior ethmoidal sinuses incidentally noted.
:
: Summary: No intracranial bleed or fracture.
:
:
: Reported by
: Dr G Alluvada MD FRCR EBIR
: GMC6047945 Consultant Radiologist
: Medica Reporting Ltd
:
:
: If you are a clinician and have a query on this report, please call Medica on 01424 377 901 or email clinical@medicagroup.co.uk

CT Head

Patient ID	1406650854:OHCP	**Patient Name**	GALLOWAY, Stephen
Sex	Male	**Date Of Birth**	14-Jun-1965
Performed	10-Dec-2024 22:13	**Order Number**	AA15119431001
Ordering Provider	Dingle (ST6)	**Status**	Final

: (Medica) Alluvada, Ganesh

: Reported by: Dr Ganesh Alluvada (Medica) (Medica Radiologist)
Reported By:Ganesh Alluvada (Medica)
Released By:Ganesh Alluvada (Medica)

XR Chest

Patient ID	1406650854:OHCP	**Patient Name**	GALLOWAY, Stephen
Sex	Male	**Date Of Birth**	14-Jun-1965
Performed	11-Jun-2024 03:14	**Order Number**	AA15102979901
Ordering Provider	Dingle (ST6)	**Status**	Final

General

Final

:
:
:
: Radiology Report
:
: Patient Name: Stephen Galloway
: DOB: 14/06/1965
: Patient ID: 1406650854
: Examination Dated: 11/06/2024 03:14
:
: Reported: 19/06/2024 07:16
: Exam: XR Chest Accession: AA15102979901
:
: Findings:
: Normal cardiomediastinal contours. No acute lung or pleural pathology demonstrated. No destructive bone lesion.
:
:
: Conclusion:
: As above
:
: 4Ways Reporting Radiologist: Ali Zaman - GMC 7041028 on 19/06/2024 07:16
: Findings
:
: Reported by: 4Ways Reporter
Reported By:4Ways Reporter
Released By:4Ways Reporter

XR Chest

Patient ID	1406650854:OHCP	**Patient Name**	GALLOWAY, Stephen
Sex	Male	**Date Of Birth**	14-Jun-1965
Performed	13-Oct-2023 11:05	**Order Number**	AA15078848401
Ordering Provider	Maxwell (Cons)	**Status**	Final

General Final

: Patient Name: Stephen, Galloway
: Patient Address: 28 Redburn Place, KA12 9BH
: DOB: 14/06/1965
: Patient ID: 1406650854
: Accession Number: AA15078848401
: Referring Cons: Gordon Maxwell (Cons)
: Referring Dept: XH CAU Pre-Arrivals
: Site: University Hospital Crosshouse

: 50788484 13/10/2023 XR Chest

: Clinical Indications
: Pleuritic chest pain with chest wall tenderness ?PTX

: Report

: No significant interval change when compared to previous x-ray dated 06/10/2021.

: No pneumothorax or pleural effusions.

: Cardiomediastinal contours are within normal limits. The lungs are clear; no collapse or consolidation. Longstanding elevation of the left hemidiaphragm. Visualised bony thorax appears intact.

: Hewitt, Lorna (Reporting Radiographer, RA71218)

: Reported by: Lorna Hewitt (Radiographer)
Reported By: Lorna Hewitt
Released By: Lorna Hewitt

XR Chest

Patient ID	1406650854:OHCP	**Patient Name**	GALLOWAY, Stephen
Sex	Male	**Date Of Birth**	14-Jun-1965
Performed	06-Oct-2021 09:24	**Order Number**	AA15003262301
Ordering Provider	Dr Jamie Adams	**Status**	Final

General Final

: Patient Name: STEPHEN, GALLOWAY
: Patient Address: 28 Redburn Place, KA12 9BH
: DOB: 14/06/1965
: Patient ID: 1406650854
: Accession Number: AA15003262301
: Referring Cons: Jamie Adams (Cons)
: Referring Dept: XH ED
: Site: University Hospital Crosshouse
:
: 50032623 06/10/2021 XR Chest
:
: Clinical Indications
: Posterior chest wall pain, SOB, cough with dirty spit, ?LRTI
:
: Report
: Comparison made with the previous radiograph of 13/12/2020.
:
: Heart not enlarged in transverse diameter and mediastinal contours are within normal limits. There is now only minor elevation of the left hemidiaphragm. Lungs are clear with no focal collapse or consolidation. Unremarkable bony thorax.
:
: Maguire, J (Cons Radiologist 7072439)
:
: Reported by: Dr John Maguire (Radiologist)
Reported By:
Released By:Dr John Maguire

General

Performed	13-Dec-2020 02:26	Order Number	AA13885531201
Ordering Provider	Dr D B Sarkar (Cons Radiologist)	Status	Final

General Final

```
:
: 13 December 2020, 02:26:00
: 13 December 2020, 02:27:00
:
: RADIOLOGY REPORT
: CHI NUMBER: 1406650854   Examination Number: 38855312   Examination Date: 13/12/2020
: Name:   Galloway, Stephen  DOB:  14/06/1965
: Address:  28 Redburn Place, , Irvine, KA12 9BH -- CC: -
: Referring Department / Location: Accident & Emergency
: Crosshouse Hospital
: Kilmarnock Road
: Crosshouse
: Ayrshire
: KA2 0BE
: Referring Consultant:   Dr E McKenzie        Clinical Specialty:   Accident & Emergency
: Date Dictated: 21/12/2020                   Typed by:  None
: Examination:  XR Chest
:
: Clinical Indication
:
: fall on stairs. left chest wall pain ?fracture ?pul contusion
:
:
: Report:
: Compared to previous chest radiographs most recently dated 9/4/2019.
: Normal cardiomediastinal outline. Lungs are clear. There is elevation of the left hemidiaphragm, this is of longstanding and is present on radiograp
:
:
  Dictating Radiologist / Clinical Specialist    Halafihi, Gillian (ST4 Reg)

  Signed by: Halafihi, Gillian (ST4 Reg)
: Verified by: Dr D B Sarkar (Cons Radiologist)
Reported By: Gillian (ST4 Reg) Halafihi
Released By: Dr D B Sarkar (Cons Radiologist)
Released On: 22/12/2020 12:35
```

CT

Performed	12-Jun-2020 00:09	Order Number	AA13840574201
Ordering Provider	(Medica) McClure.M (3488511)	Status	Final

CT Final

: 12 June 2020, 00:09:00
: 12 June 2020, 00:09:00
:
: RADIOLOGY REPORT
: CHI NUMBER: 1406650854 Examination Number: 38405742 Examination Date: 11/06/2020
: Name: GALLOWAY, STEPHEN DOB: 14/06/1965
: Address: 28 REDBURN PLACE, AYRSHIRE, IRVINE, KA12 9BH -- CC: -
: Referring Department / Location: Accident & Emergency
: Crosshouse Hospital
: Kilmarnock Road
: Crosshouse
: Ayrshire
: KA2 0BE
: Referring Consultant: Dr. C. McGuffie Clinical Specialty: Accident & Emergency
: Date Dictated: 12/06/2020 Typed by: (Medica) McClure.M (3488511)
: Examination: CT Head
:
: Clinical Indication
:
: Green - intoxicated, possible fall at home, GCS 14, dried blood over forehead from no obvious source ?bleed
:
:
: Report:
: Date of Examination: 11/06/2020
:
: Name of Procedure and Technique: CT head.
:
Clinical Information: Intoxicated, possible fall at home, GCS 14/15. Dry blood over forehead? ICH.

. Findings: Comparison with previous CT head dated 13/03/2016 generalised moderate cerebral cortical atrophy, more than expected for age. Bilateral mo
:
: The posterior fossa, including the brainstem, cerebellar hemispheres and fourth ventricle appear normal. The craniocervical junction and pituitary g
:
: Conclusion:
: 1. Mild generalised cerebral cortical atrophy and bilateral periventricular chronic small vessel ischaemic change.
: 2. No acute intracranial haemorrhage or vault fracture.
: 3. No acute major territorial evolving infarction.
: 4. No CT evidence of raised intracranial pressure.
:
: Report Date: 12/06/2020
:
: Reporting Consultant: Dr MJ McClure. Consultant Radiologist,
:
: GMC: 3488511 Medica Reporting Ltd
:
: Dictating Radiologist / Clinical Specialist (Medica) McClure.M (3488511)
:
: Verified by: (Medica) McClure.M (3488511)
Reported By: (Medica) McClure.M (3488511)
Released By: (Medica) McClure.M (3488511)
Released On: 12/06/2020 12:34

General

Performed	03-Sep-2019 15:43	Order Number	AAA3768002901
Ordering Provider	Blower.Caroline (Con Radiographer)	Status	Final

General Final

```
:
: 03 September 2019, 15:43:00
: 03 September 2019, 15:46:00
:
: RADIOLOGY REPORT
: CHI NUMBER: 1406650854   Examination Number: 37680029   Examination Date: 03/09/2019
: Name:   Galloway, Stephen  DOB:  14/06/1965
: Address:  28 Redburn Place, , Irvine, KA12 9BH -- CC: -
: Referring Department / Location: WALKER GARRY
: 9 FREW TERRACE
: IRVINE
:
:
: KA12 9DZ
: Referring Consultant:   GP Requestor        Clinical Specialty:   General Practice
: Date Dictated: 04/09/2019                  Typed by:  None
: Examination:  XR Shoulder Rt
:
: Clinical Indication
:
: pain 10/12 r shoulder,prev painter/decorator,no trauma, limited abduction . 'click' around a-c joint,pain l;at upper arm ?o.a changes
:
:
: Report:
: Minor narrowing is seen at the acromio-clavicular joint in keeping with early degenerative change.
  No other significant bone or joint abnormality is seen.

:
: Dictating Radiologist / Clinical Specialist    Blower.Caroline (Con Radiographer)
:
: Verified by: Blower.Caroline (Con Radiographer)
Reported By: Blower.Caroline (Con Radiographer)
Released By: Blower.Caroline (Con Radiographer)
Released On: 06/09/2019 11:59
```

General

Performed	09-Apr-2019 22:21	Order Number	AA13726700901
Ordering Provider	(Medica) Williams	Status	Final

General Final

```
:
: 09 April 2019, 22:21:00
: 09 April 2019, 22:23:00
:
: RADIOLOGY REPORT
: CHI NUMBER: 1406650854   Examination Number: 37267009   Examination Date: 09/04/2019
: Name:   GALLOWAY, STEPHEN  DOB:  14/06/1965
: Address:  28 REDBURN PLACE, AYRSHIRE, IRVINE, KA12 9BH -- CC: -
: Referring Department / Location: Accident & Emergency
: Crosshouse Hospital
: Kilmarnock Road
: Crosshouse
: Ayrshire
: KA2 0BE
: Referring Consultant:   Dr L Black        Clinical Specialty:   Accident & Emergency
: Date Dictated: 12/05/2019                  Typed by:  (Medica) Williams, Paul
: Examination:  XR Chest
:
  Clinical Indication

: increased sob, widespread exp wheeze, crackles right base ?consolidation
:
:
: Report:
: Heart size normal. Elevation of the right hemidiaphragm is unchanged since 21/1/2019. The lungs are clear.
:
: Report Date : 12/05/2019
: Reporting Consultant: Dr Paul Williams. Consultant Radiologist   GMC Number: 2956581
: Medica Reporting Ltd
:
:
:
: Dictating Radiologist / Clinical Specialist    (Medica) Williams, Paul GMC 2956581
:
: Verified by: (Medica) Williams, Paul GMC 2956581
Reported By: Paul GMC 2956581 (Medica) Williams
Released By: Paul GMC 2956581 (Medica) Williams.
Released On: 13/05/2019 11:46
```

General

Performed	21-Jan-2019 17:20	Order Number	AA13703076801
Ordering Provider	Dr A Taha	Status	Final

General Final

: 21 January 2019, 17:20:00
: 21 January 2019, 17:21:00
:
: RADIOLOGY REPORT
: CHI NUMBER: 1406650854, Examination Number: 37030768 Examination Date: 21/01/2019
: Name: Galloway, Stephen DOB: 14/06/1965
: Address: 28 Redburn Place, , Irvine, KA12 9BH -- CC: -
: Referring Department / Location: XH CAU In-Patient
:
:
:
:
: Referring Consultant: Dr G Williams Clinical Specialty: General Medicine
: Date Dictated: 07/02/2019 Typed by: (Medica) Dr Peter Holland
: Examination: XR Chest
:
: Clinical Indication
:
: Unwell, cough, spit, pyrexial ?CAP
:
:
: Report:
: Chest x-ray:
: There is slight elevation of the left hemidiaphragm that was not present on a film from 2017, though no obvious cause for this is identified. Normal
:
: Reported by Dr. Peter Holland, Medica Consultant Radiologist, GMC: 2715328

Dictating Radiologist / Clinical Specialist (Medica) Dr Peter Holland
:
: Verified by: (Medica) Dr Peter Holland
Reported By: (Medica) Dr Peter Holland
Released By: (Medica) Dr Peter Holland
Released On: 08/02/2019 11:20

US

Performed 26-Nov-2018 15:31 Order Number AA13683323501
Ordering Provider Dr Stacy Smith Status Final

US Final

: 26 November 2018, 15:31:00
: 26 November 2018, 15:40:00
:
: RADIOLOGY REPORT
: CHI NUMBER: 1406650854 Examination Number: 36833235 Examination Date: 26/11/2018
: Name: Galloway, Stephen DOB: 14/06/1965
: Address: 28 Redburn Place, Irvine, Ayrshire, KA12 9BH -- CC: -
: Referring Department / Location: XH OP (Ad-Hoc) TRAK USE ONLY
:
:
:
:
:
: Referring Consultant: Smith, Stacy (Cons) Clinical Specialty: General Medicine
: Date Dictated: 26/11/2018 Typed by: None
Examination: US Abdomen

: Clinical Indication
:
: History of alcohol excess, deranged LFT ?cirrhosis
:
:
: Report:
: The liver, gallbladder, bile ducts, abdominal aorta, kidneys and spleen appear normal.
: The pancreas was obscured therefore not examined.
:
:
: Dictating Radiologist / Clinical Specialist Gayle Siedlecki (Radiographer)
:
: Verified by: Gayle Siedlecki (Radiographer)
Reported By: Gayle Siedlecki (Radiographer)
Released By: Gayle Siedlecki (Radiographer)
Released On: 27/11/2018 08:31

CT

Performed	27-Oct-2017 13:11	Order Number	A103572486201
Ordering Provider	Dr Gabor Kiss	Status	Final

CT Final

: 27 October 2017, 13:11:00
: 27 October 2017, 13:11:00
:
: RADIOLOGY REPORT
: CHI NUMBER: 1406650854 Examination Number: 35724862 Examination Date: 26/10/2017
: Name: GALLOWAY, STEPHEN DOB: 14/06/1965
: Address: 28 REDBURN PLACE, , IRVINE, KA12 9BH -- CC: -
: Referring Department / Location: AYR SUITE F
:
:
:
:
: Referring Consultant: Dr. G. Kiss
: Date Dictated: 27/10/2017 Typed by: Fraser Kenneth
: Examination: CT Head
:
: Clinical Indication
:
: Sudden onset unexplained left sided sensory symptoms since a year. MRI spine cervical/brachial plexus and NCV turned out to be normal. Patient clai
:
: This examination has been carried out at the Golden Jubilee National Hospital Clydebank
:
: CT Head: Unenhanced.
:
: Comparison with a previous CT head and 13/03/2016.
:
No significant interval change identified since the previous CT.

Minor periventricular and patchy deep white matter low attenuation adjacent to the occipital
: horns of the lateral ventricles is again seen bilaterally. These findings are nonspecific but
: could represent early small vessel disease.
:
: Normal appearance of the ventricular system , posterior fossa and midline structures.
:
: Summary:
:
: No significant interval change since the previous CT
:
:
:
: Verified by:
: Joanna Mcneil Gmc6077441
: (Consultant Radiologist)
: Reported Created: 27/10/2017 11:20:26
:
: This report has been cut and pasted by KF
: This report was check by DS/LM.
:
: Dictating Radiologist / Clinical Specialist Con Radiologist GJNH
:
: Verified by: McCreadie, Catherine (Admin)
Reported By: Con Radiologist GJNH
Released By: Catherine (Admin) McCreadie
Released On: 27/10/2017 16:32

General

Performed	07-Sep-2017 08:21	Order Number	AA13557997401
Ordering Provider	Jennifer Wells (Rep Radiographer)	Status	Final

General Final

:
: 07 September 2017, 08:21:00
: 07 September 2017, 08:33:00
:
: RADIOLOGY REPORT
: CHI NUMBER: 1406650854 Examination Number: 35579974 Examination Date: 07/09/2017
: Name: GALLOWAY, STEPHEN DOB: 14/06/1965
: Address: 28 REDBURN PLACE, , IRVINE, KA12 9BH -- CC: -
: Referring Department / Location: Accident & Emergency
: Crosshouse Hospital
: Kilmarnock Road
: Crosshouse
: Ayrshire
: KA2 0BE
: Referring Consultant: Hopkins.Tom (Cons)
: Date Dictated: 07/09/2017 Typed by: None
: Examination: XR Radius and Ulna Lt, XR Elbow Lt, XR Scapula Rt
:
: Clinical Indication
:
: Fell from ladder last night approximately 12 feet. Pain and tenderness right lower scapula ? fracture. Unable to extend fully at elbow ? fracture. T
:
:
: Report:
: RIGHT SCAPULA
: The scapula body is obscured by the humeral shaft on the Y view. No acute bony injury is seen on the available images.
: LEFT ELBOW
: No effusion or acute bony injury is seen.
LEFT FOREARM
No specific clinical history has been provided to justify x-raying the entire forearm.
: No acute bony injury is seen.
:
:
: Dictating Radiologist / Clinical Specialist Jennifer Wells (Rep Radiographer)
:
: Verified by: Jennifer Wells (Rep Radiographer)
Reported By: Jennifer Wells (Rep Radiographer)
Released By: Jennifer Wells (Rep Radiographer)
Released On: 07/09/2017 12:48

General

Performed	07-Sep-2017 08:21	Order Number	AA13557997402
Ordering Provider	Jennifer Wells (Rep Radiographer)	Status	Final

General Final

: 07 September 2017, 08:21:00
: 07 September 2017, 08:33:00
:
: RADIOLOGY REPORT
: CHI NUMBER: 1406650854 Examination Number: 35579974 Examination Date: 07/09/2017
: Name: GALLOWAY, STEPHEN DOB: 14/06/1965
: Address: 28 REDBURN PLACE, , IRVINE, KA12 9BH -- CC: -
: Referring Department / Location: Accident & Emergency
: Crosshouse Hospital
: Kilmarnock Road
: Crosshouse
: Ayrshire
: KA2 0BE
: Referring Consultant: Hopkins.Tom (Cons)
: Date Dictated: 07/09/2017 Typed by: None
: Examination: XR Radius and Ulna Lt, XR Elbow Lt, XR Scapula Rt
:
: Clinical Indication
:
: Fell from ladder last night approximately 12 feet. Pain and tenderness right lower scapula ? fracture. Unable to extend fully at elbow ? fracture. T
:
:
: Report:
: RIGHT SCAPULA
: The scapula body is obscured by the humeral shaft on the Y view. No acute bony injury is seen on the available images.
: LEFT ELBOW
: No effusion or acute bony injury is seen.
: LEFT FOREARM
No specific clinical history has been provided to justify x-raying the entire forearm.
No acute bony injury is seen.
:
:
: Dictating Radiologist / Clinical Specialist Jennifer Wells (Rep Radiographer)
:
: Verified by: Jennifer Wells (Rep Radiographer)
Reported By: Jennifer Wells (Rep Radiographer)
Released By: Jennifer Wells (Rep Radiographer)
Released On: 07/09/2017 12:48

General

Performed	20-Apr-2017 16:20	Order Number	AAA3517685301
Ordering Provider	(Medica) Kember	Status	Final

General Final

```
:
: 20 April 2017, 16:20:00
: 20 April 2017, 16:23:00
:
: RADIOLOGY REPORT
: CHI NUMBER: 1406650854   Examination Number: 35176853   Examination Date: 20/04/2017
: Name:   Galloway, Stephen  DOB:  14/06/1965
: Address:  28 Redburn Place, , Irvine, KA12 9BH -- CC: -
: Referring Department / Location: Poddar.Amer (Loc GP)
: Frew Terrace Surgery
: 9 Frew Terrace
: Irvine
:
: KA12 9DZ
: Referring Consultant: GP Requestor
: Date Dictated: 04/05/2017                Typed by:  (Medica)Kember, Peter
: Examination:  XR Chest
:
: Clinical Indication
:
: Lateral left sided chest ?lung pathology. Smokes roll-ups (5/day).
:
:
: Report:
: The heart is not enlarged. The lungs appear clear.
:
:
: Dictating Radiologist / Clinical Specialist    (Medica) Kember, Peter
:
: Verified by: (Medica) Kember, Peter
```

Reported By: Peter (Medica) Kember
Released By: Peter (Medica) Kember
Released On: 09/05/2017 19:09

MR

Performed	12-Sep-2016 18:50	Order Number	AA13454152001
Ordering Provider	Dr David Wilkin	Status	Final

MR Final

: 12 September 2016, 18:50:00
: 12 September 2016, 19:33:00
:
: RADIOLOGY REPORT
: CHI NUMBER: 1406650854 Examination Number: 34541520 Examination Date: 12/09/2016
: Name: Galloway, Stephen DOB: 14/06/1965
: Address: 28 Redburn Place, , Irvine, KA12 9BH -- CC: -
: Referring Department / Location: XH CAU In-Patient
:
:
:
:
: Referring Consultant: Dr D Wilkin Med Cons
: Date Dictated: 02/10/2016 Typed by: None
: Examination: MRI Spine Cervical, MRI Brachial Plexus
:
: Clinical Indication
:
: OUTPATIENT MRI. 51yo presenting with intermittent paraesthesia of the entire left arm. Reduced sensation in a C5/6 C6/7 brachial plexus distribution
:
:
: Report:
: Cervical spine: Standard protocol.
: At C5-C6 there is mild degenerative changes. There is a broad-based posterior disc osteophyte bar which is impinging on the cord but the cord does
: At C6-C7 there is moderate degenerative changes, but there are no posterior disc osteophyte bars and the cord appears uncompromised as do the exitin
: The cord shows normal signal and there is normal cranio-cervical junction.
Brachial plexus:
No obvious brachial plexus injury is evident. No abnormal signal evident and there is no mass lesion, cystic changes or muscle signal changes to su

:
: Dictating Radiologist / Clinical Specialist Dr S Rasul(Cons Radiologist)*
:
: Verified by: Dr S Rasul(Cons Radiologist)*
Reported By: Dr S Rasul(Cons Radiologist)*
Released By: Dr S Rasul(Cons Radiologist)*
Released On: 01/12/2016 08:57

MR

Performed	12-Sep-2016 18:50	Order Number	AA13454152002
Ordering Provider	Dr David Wilkin	Status	Final

MR Final

: 12 September 2016, 18:50:00
: 12 September 2016, 19:33:00
:
: RADIOLOGY REPORT
: CHI NUMBER: 1406650854 Examination Number: 34541520 Examination Date: 12/09/2016
: Name: Galloway, Stephen DOB: 14/06/1965
: Address: 28 Redburn Place, , Irvine, KA12 9BH -- CC: -
: Referring Department / Location: XH CAU In-Patient
:
:
:
:
: Referring Consultant: Dr D Wilkin Med Cons
: Date Dictated: 02/10/2016 Typed by: None
: Examination: MRI Spine Cervical, MRI Brachial Plexus
:
: Clinical Indication
:
: OUTPATIENT MRI. 51yo presenting with intermittent paraesthesia of the entire left arm. Reduced sensation in a C5/6 C6/7 brachial plexus distribution
:
:
: Report:
: Cervical spine: Standard protocol.
: At C5-C6 there is mild degenerative changes. There is a broad-based posterior disc osteophyte bar which is impinging on the cord but the cord does
: At C6-C7 there is moderate degenerative changes, but there are no posterior disc osteophyte bars and the cord appears uncompromised as do the exitin
: The cord shows normal signal and there is normal cranio-cervical junction.
Brachial plexus:
No obvious brachial plexus injury is evident. No abnormal signal evident and there is no mass lesion, cystic changes or muscle signal changes to su
:
: Dictating Radiologist / Clinical Specialist Dr S Rasul(Cons Radiologist)*
:
: Verified by: Dr S Rasul(Cons Radiologist)*
Reported By: Dr S Rasul(Cons Radiologist)*
Released By: Dr S Rasul(Cons Radiologist)*
Released On: 01/12/2016 08:57

General

Performed	24-Aug-2016 13:56	Order Number	AA13452980601
Ordering Provider	Dr A K Adebanjo	Status	Final

General **Final**

: 24 August 2016, 13:56:00
: 24 August 2016, 13:58:00
:
: RADIOLOGY REPORT
: CHI NUMBER: 1406650854 Examination Number: 34529806 Examination Date: 24/08/2016
: Name: Galloway, Stephen DOB: 14/06/1965
: Address: 28 Redburn Place, , Irvine, KA12 9BH -- CC: -
: Referring Department / Location: Accident & Emergency
: Crosshouse Hospital
: Kilmarnock Road
: Crosshouse
: Ayrshire
: KA2 0BE
: Referring Consultant: Hopkins.Tom (Cons)
: Date Dictated: 24/08/2016 Typed by: None
: Examination: XR Cervical Spine, XR Chest
:
: Clinical Indication
:
: paraesthesia down left aside, associated headache and lateral left chest pain. ?lung pathology, ?c-spine degeneration causing spondyloarthropathy
:
:
: Report:
: Cervical spine.
: Spondylitic changes of disc space narrowing at C5-C6 and C6-C7 levels with associated anterior and bridging marginal osteophytes.
: Slight reversal of normal lordosis at C6-C7 level with relative increased narrowing at the anterior aspect of the disc space.
: Normal vertebral body heights.
: Prominent transverse processes of C7 vertebra slightly more marked on the left. There cartilage tips may cause impingement on adjacent neurovascula
Minor degenerative sclerosis in the mid and lower cervical facet joints..
Chest.
: No focal consolidation or atelectasis or mass lesion or pleural effusion. The hilar shadows and mediastinal contour are normal. No evidence of car
:
:
: Dictating Radiologist / Clinical Specialist Dr A K Adebanjo
:
: Verified by: Dr A K Adebanjo
Reported By: Dr A K Adebanjo
Released By: Dr A K Adebanjo
Released On: 25/08/2016 11:59

General

Performed	24-Aug-2016 13:56	Order Number	AA13452980602
Ordering Provider	Dr A K Adebanjo	Status	Final

General Final

: 24 August 2016, 13:56:00
: 24 August 2016, 13:58:00
:
: RADIOLOGY REPORT
: CHI NUMBER: 1406650854 Examination Number: 34529806 Examination Date: 24/08/2016
: Name: Galloway, Stephen DOB: 14/06/1965
: Address: 28 Redburn Place, , Irvine, KA12 9BH -- CC:
: Referring Department / Location: Accident & Emergency
: Crosshouse Hospital
: Kilmarnock Road
: Crosshouse
: Ayrshire
: KA2 0BE
: Referring Consultant: Hopkins.Tom (Cons)
: Date Dictated: 24/08/2016 Typed by: None
: Examination: XR Cervical Spine, XR Chest
:
: Clinical Indication
:
: paraesthesia down left aside, associated headache and lateral left chest pain. ?lung pathology, ?c-spine degeneration causing spondyloarthropathy
:
:
: Report:
: Cervical spine.
: Spondylitic changes of disc space narrowing at C5-C6 and C6-C7 levels with associated anterior and bridging marginal osteophytes.
: Slight reversal of normal lordosis at C6-C7 level with relative increased narrowing at the anterior aspect of the disc space.
: Normal vertebral body heights.
: Prominent transverse processes of C7 vertebra slightly more marked on the left. There cartilage tips may cause impingement on adjacent neurovascula
Minor degenerative sclerosis in the mid and lower cervical facet joints..
Chest.
: No focal consolidation or atelectasis or mass lesion or pleural effusion. The hilar shadows and mediastinal contour are normal. No evidence of car
:
:
: Dictating Radiologist / Clinical Specialist Dr A K Adebanjo
:
: Verified by: Dr A K Adebanjo
Reported By: Dr A K Adebanjo
Released By: Dr A K Adebanjo
Released On: 25/08/2016 11:59

General

Performed	21-Jan-2015 18:47	Order Number	AA13304349701
Ordering Provider	Dr M A H McMillan (Consultant)	Status	Final

General Final

```
:
: 21 January 2015, 18:47:00
: 21 January 2015, 18:47:00
:
: RADIOLOGY REPORT
: CHI NUMBER: 1406650854   Examination Number: 33043497   Examination Date: 21/01/2015
: Name:   GALLOWAY, STEPHEN  DOB:  14/06/1965
: Address:  28 REDBURN PLACE, , IRVINE, KA12 9BH -- CC: -
: Referring Department / Location: Accident & Emergency
: Crosshouse Hospital
: Kilmarnock Road
: Crosshouse
: Ayrshire
: KA2 0BE
: Referring Consultant: Dr D Chung
: Date Dictated: 22/01/2015                Typed by:  None
: Examination:  XR Chest

: Clinical Indication
:
: Cardiac chest pain but also productive cough and few creps left base ?consolidation
:
:
: Report: Chest
:
: No focal collapse or consolidation.  The heart is not enlarged.  The lungs are clear.
:
:
:
: Dictating Radiologist / Clinical Specialist    Dr M A H  McMillan (Consultant)
:
: Verified by: Dr M A H  McMillan (Consultant)
Reported By: Dr M A H  McMillan (Consultant)
Released By: Dr M A H  McMillan (Consultant)
Released On: 23/01/2015 12:18
```

Ryan 24/2
30 DIS

Department of Radiology

Accident & Emergency Dept
Crosshouse hospital
Kilmarnock Road
Kilmarnock
KA2 0Be

RECEIVED AFTER PATIENT'S DISCHARGE
14 FEB 2019

NHS
Ayrshire & Arran

11 FEB 2019

RADIOLOGY REPORT

CHI NUMBER: 1406650854 **Examination Number:** 37030768 **Examination Date:** 21/01/2019
Name: Galloway, Stephen DOB: 14/06/1965
Address: 28 Redburn Place, , Irvine, KA12 9BH -- **CC:** -

Referring Department / Location: XH CAU In-Patient

Referring Consultant: Dr G Williams **Clinical Specialty:** General Medicine

Date Dictated: 07/02/2019 **Typed by:** (Medica) Dr Peter Holland

Examination: XR Chest

Clinical Indication

Unwell, cough, spit, pyrexial ?CAP

Report:

- Chest x-ray:

There is slight elevation of the left hemidiaphragm that was not present on a film from 2017, though no obvious cause for this is identified. Normal heart size and mediastinal outline. No focal hilar pathology identified. There is no focal active lung pathology.

Reported by Dr. Peter Holland, Medica Consultant Radiologist, GMC: 2715328

RV 2715328

Dictating Radiologist / Clinical Specialist (Medica) Dr Peter Holland

Verified by: (Medica) Dr Peter Holland

Examination Number: 37030768 **Examination Date:** 21/01/2019
Name: Galloway, Stephen **DOB:** 14/06/1965
Dose :- .84 dGy cm2

Dr Smith's docket 27/11

Department of Radiology

UNIVERSITY HOSPITAL CROSSHOUSE
Medical Imaging Department
CROSSHOUSE
Kilmarnock
KA2 0BE

NHS Ayrshire & Arran

RADIOLOGY REPORT

CHI NUMBER: 1406650854 **Examination Number:** 36833235 **Examination Date:** 26/11/2018
Name: Galloway, Stephen DOB: 14/06/1965
Address: 28 Redburn Place, Irvine, Ayrshire, KA12 9BH -- CC: -
Referring Department / Location: XH OP (Ad-Hoc) TRAK USE ONLY
Referring Consultant: Smith, Stacy (Cons) **Clinical Specialty:** General Medicine
Date Dictated: 26/11/2018 **Typed by:** None
Examination: US Abdomen

Clinical Indication

History of alcohol excess, deranged LFT ?cirrhosis

Report:

The liver, gallbladder, bile ducts, abdominal aorta, kidneys and spleen appear normal.

The pancreas was obscured therefore not examined.

Dictating Radiologist / Clinical Specialist Gayle Siedlecki (Radiographer)

Verified by: Gayle Siedlecki (Radiographer)

SMITH 6/16326

RECEIVED
28 NOV 2018

1406650854] **Examination Number:** 36833235 **Examination Date:** 26/11/2018
Name: Galloway, Stephen **DOB:** 14/06/1965
Dose :-

UNIVERSITY HOSPITAL AYR
Medical Imaging Department
Dalmellington Road
AYR
KA6 6DX

NHS Ayrshire & Arran

RADIOLOGY REPORT

CHI NUMBER: 1406650854 **Examination Number:** 35724862 **Examination Date:** 26/10/2017
Name: GALLOWAY, STEPHEN DOB: 14/06/1965
Address: 28 REDBURN PLACE, , IRVINE, KA12 9BH -- **CC:** -
Referring Department / Location: AYR SUITE F
Referring Consultant: Dr. G. Kiss
Date Dictated: 27/10/2017 **Typed by:** Fraser Kenneth
Examination: CT Head

Clinical Indication

Sudden onset unexplained left sided sensory symptoms since a year. MRI spine cervical/brachial plexus and NCV turned out to be normal. Patient claims he had LL symptoms at the beginning. No obj. neur. sign. Please perform CT head to rule out right sided vascular lesion! Thank You!

This examination has been carried out at the Golden Jubilee National Hospital Clydebank

CT Head: Unenhanced.

Comparison with a previous CT head and 13/03/2016.

No significant interval change identified since the previous CT.

Minor periventricular and patchy deep white matter low attenuation adjacent to the occipital horns of the lateral ventricles is again seen bilaterally. These findings are nonspecific but could represent early small vessel disease.

Normal appearance of the ventricular system , posterior fossa and midline structures.

Summary:

No significant interval change since the previous CT

Dr Gabor Kiss
Locum Consultant in Neurology
GMC 7421239 Page.....

RECEIVED
31 OCT 2017

UNIVERSITY HOSPITAL AYR
Medical Imaging Department
Dalmellington Road
AYR
KA6 6DX

NHS Ayrshire & Arran

Verified by:
Joanna Mcneil Gmc6077441
(Consultant Radiologist)
Reported Created: 27/10/2017 11:20:26

This report has been cut and pasted by KF
This report was check by DS/LM.

Dictating Radiologist / Clinical Specialist Con Radiologist GJNH

Verified by: McCreadie, Catherine (Admin)

Examination Number: 35724862 Examination Date: 26/10/2017
Name: GALLOWAY, STEPHEN DOB: 14/06/1965
Dose :- 0 cGy cm2

RADIOLOGY REPORT

CHI NUMBER: 1406650854 Examination Number: 34541520 Examination Date: 12/09/2016

Name: Galloway, Stephen DOB: 14/06/1965

Address: 28 Redburn Place, , Irvine, KA12 9BH -- CC: -

Referring Department / Location: XH CAU In-Patient

Referring Consultant: Dr D Wilkin Med Cons

Date Dictated: 02/10/2016 Typed by: None

Examination: MRI Spine Cervical, MRI Brachial Plexus

Clinical Indication

OUTPATIENT MRI. 51yo presenting with intermittent paraesthesia of the entire left arm. Reduced sensation in a C5/6 C6/7 brachial plexus distribution (works as a painter and decorator - ambidextrous). No loss of fine motor control or grip strength. Previous RTA with multiple head injury last year but self discharged and defaulted from follow up. C5/6, C6/7 osteophytosis and spondylitic changes on C-spine XRays. ?C5/6 6/7 nerve root impingement ? brachial plexus injury.

Report:

Cervical spine: Standard protocol.

At C5-C6 there is mild degenerative changes. There is a broad-based posterior disc osteophyte bar which is impinging on the cord but the cord does not does appearcompressed. The exiting nerve roots appear uncompromised.

At C6-C7 there is moderate degenerative changes, but there are no posterior disc osteophyte bars and the cord appears uncompromised as do the exiting nerve roots.

The cord shows normal signal and there is normal cranio-cervical junction.

Brachial plexus:

No obvious brachial plexus injury is evident. No abnormal signal evident and there is no mass lesion, cystic changes or muscle signal changes to suggest soft tissue injury.

Dictating Radiologist / Clinical Specialist Dr S Rasul(Cons Radiologist)*

Dr. Mahanth Manuel
Consultant Phys
Acute Me
GMC 6041033 Page 3763

Verified by: Dr S Rasul(Cons Radiologist)*

RADIOLOGY

STA0169

14	BELOW
13	BELOW
12	BELOW
11	BELOW
10	BELOW
9	BELOW
8	BELOW
7	BELOW
6	BELOW
5	BELOW

Name: GALLOWAY,STEPHEN
11 CORSE AVE
IRVINE
Sex: M DOB: 14/06/1965
Location: AE
Unit £: A9000066660

X-RAY REPORT

Crosshouse Hospital

Requesting Dr: LANNIGAN,A.

Exam Date/Time: 12/05/02 1448

ak clinic
AR Step
2015

chk-in £	Order	Code	Exam
893804	0001	1125	Finger Ring*R

A&E Number : NA

Clinical History :: Laceration, foreign body.

RIGHT RING FINGER

No opaque foreign body is demonstrated.

Reported By: Neil Corrigan Typed By: EC 14/05/02 0900

DEPARTMENT OF RADIOLOGY

DEPARTMENT OF RADIOLOGY

Verified

Verified

10 OCT 1999 22:20 11:01 11 OCT 99 12:14

RADIOLOGY

Name: GALLOWAY,STEPHEN
8 CARMEL DRIVE
IRVINE
Sex: M DOB: 14/06/65
Location: AE
Unit #: A9000066660

Crossnouse Hospital
X-RAY REPORT
Requesting Dr: LANNIGAN,A.
Exam Date/Time: 09/12/00 1001

468158

Chk-in #	Order	Code	Exam
768191	0001	1240	Mandible

#A&E Number : 50169

No bony injury is seen.

Reported By: George McLaughli Typed By: CK 12/12/00 1010

DEPARTMENT OF RADIOLOGY

Verified

10 OCT 1999 22:20 11:01 11 OCT 99 12:14

RADIOLOGY

Crosshouse Hospital

X-RAY REPORT

Name: GALLOWAY,STEPHEN
8 CARMEL DRIVE
IRVINE
Sex: M DOB: 14/06/65
Location: AE
Unit #: A9000066660

Requesting Dr: LANNIGAN,A.

Exam Date/Time: 09/12/00 1001

chk-in #	Order	Code	Exam
768191	0001	1260	OPT

MFS 27/12

#A&E Number : 50169

468168

No bony injury is seen.

Reported By: George McLaughli Typed By: AK 17/01/01 1148

(F)

DEPARTMENT OF RADIOLOGY

Verified

10 OCT 1999 22:20 11:01 11 OCT 99 12:14

RADIOLOGY

99/210794 CROSSHOUSE (A&E)
GALLOWAY STEPHEN 14 JUN 1965 M CAS
41 MAIN RD ACC & EM
SPRINGSIDE R99/68449P Dr. Zaidi S.M.H.

CHEST (10 OCT 1999)

No abnormality noted of the heart or lung fields.

F

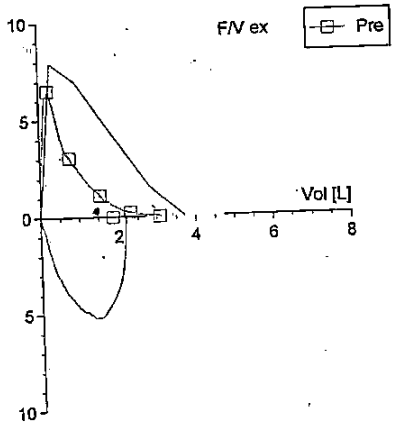
Dr. P. CRUMLISH/IGPC Typed - 11 OCT 99 Xray-99/210794
Examined FIRM A&E- 40936/99
10 OCT 1999 22:20 11:01 11 OCT 99 12:14

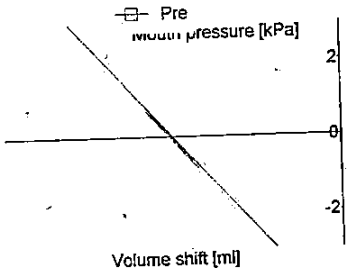
NHS Ayrshire & Arran

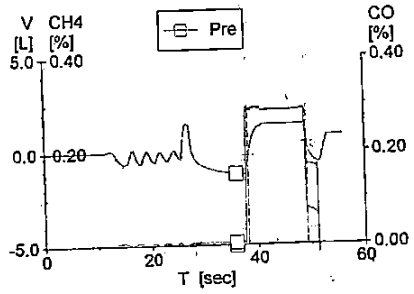
Pulmonary Function Laboratory
University Hospitals Ayr / Crosshouse

Last Name:	Galloway	Identification:	1406650854	Measurement date		11.04.19
First Name:	Stephen	Age:	53 Years	Measurement time		17:33
Hospital:	Tested at Cross	Height:	164 cm	Ambient air pressure	mmHg	765
Date of Birth:	14/06/1965	Weight:	70.0 kg	Ambient air temperature	°C	29
Gender:	male	BMI:	26	Ambient air humidity	%	12
Operator:	Adair Elizabeth	Physician:	Dr Taha			
Any Info:	42pk/yrs					

Combined Plethysmography Report







		Ref	Pre	Pre %Ref
SPIROMETRY				
FVC	L	3.73	3.09	82.8
FEV 1	L	3.02	1.87	61.9
FEV 1 % FVC	%	77.67	60.65	78.1
MFEF 75/25	L/s	3.60	0.73	20.3
PEF	L/s	7.94	6.52	82.1
FET 100	sec		13.23	
FVC IN	L	3.87	2.19	56.7
FIF 50	L/s		4.91	
LUNG_ECODE				
MVV	L/min	114.37		
LUNG VOLUMES				
TLC	L	6.02	5.49	91.1
VC	L	3.87	3.00	77.6
IC	L	2.73	2.14	78.4
FRCpleth	L	3.22	3.35	103.8
VT	L	0.50	0.62	124.2
ERV	L	1.14	0.86	75.6
RV	L	2.08	2.48	119.2
RV % TLC	%	34.63	45.28	130.8
AIRWAYS RESISTANCE				
Raw	kPa/(L/s)	0.30	0.31	104.2
Gaw	(L/s)/kPa	3.33	3.20	96.0
sRaw	kPa*s	1.18	1.14	97.2
sGaw	1/(kPa*s)	0.85	0.87	102.9
SINGLE BREATH DIFFUSION				
DLCO_SB		8.69	6.53	75.2
DLCOcSB		8.69	6.53	75.2
KCO_SB		1.44	1.70	118.1
KCOc_SB		1.44	1.70	118.1
VA_SB		5.87	3.83	65.3
VIN L			0.00	
BHT			11.01	

Comment

Patient struggled with testing due to coughing. Only one DLCO measurement performed due to this.
Moderate ariflow obstruction
Gillian Toole
Now on portal

DEPARTMENT OF CLINICAL NEUROPHYSIOLOGY

THE QUEEN ELIZABETH UNIVERSITY HOSPITAL GLASGOW
1345 GOVAN ROAD
GLASGOW G51 4TF

Consultant Clinical Neurophysiologists:

Dr Cameron Mann	0141-201 1954	fax 0141-201-2734
Dr Arup Mallik	0141-201 2480	
Dr Veronica Leach	0141-201 2462	
Dr Shona Livingstone	0141-201 2462	
Dr Aisyah Yaacob	0141-201 2480	

EMG REPORT

Patient:	STEPHEN GALLOWAY
Patient ID	1406650854
Date of Birth:	14/06/1965
Address:	28 REDBURN PLACE, IRVINE AYRSHIRE, KA12 9BH
Referred by:	Patrick Anstey, Clinical Fellow in Acute Medicine (Dr M Manuel)
Hospital:	Crosshouse Hospital
Ward or OP:	op

CC:

Report

Motor conduction studies were carried out from both median nerves. M responses were normal, allowing for temperature. F waves were also normal from both APB muscles. Median and ulnar sensory responses were normal from relevant digits allowing for rather cold extremities. Needle EMG studies were carried out from left triceps muscle. No significant neurogenic change was seen at this site.

Opinion

This patient described to me episodes of left-sided paraesthesia affecting his arm, face and leg and clearly nerve conduction/EMG studies are not going to provide an explanation for that symptomatology.

Today's upper limb conduction studies are normal on the left side and comparable to the right and needle EMG studies from a C7 muscle on the left side are likewise unremarkable. No helpful localising abnormalities, therefore, seen in today's studies. I do not know what else this patient has had but I would have thought a formal Neurology review would be entirely appropriate in a case like this.

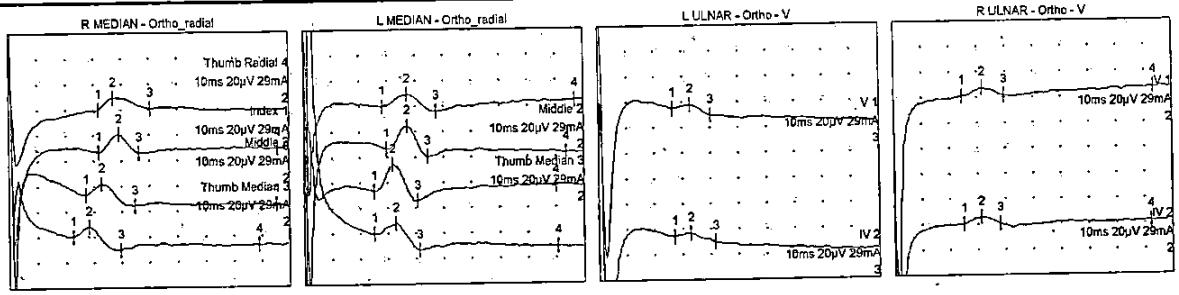
ev

Dr. Mahanth Manuel
Consultant Physician
Acute Medicine
GMC 6041033 Page-376?

Dr Cameron Mann
Consultant Clinical Neurophysiologist
CM/SL – typed 04/01/2017

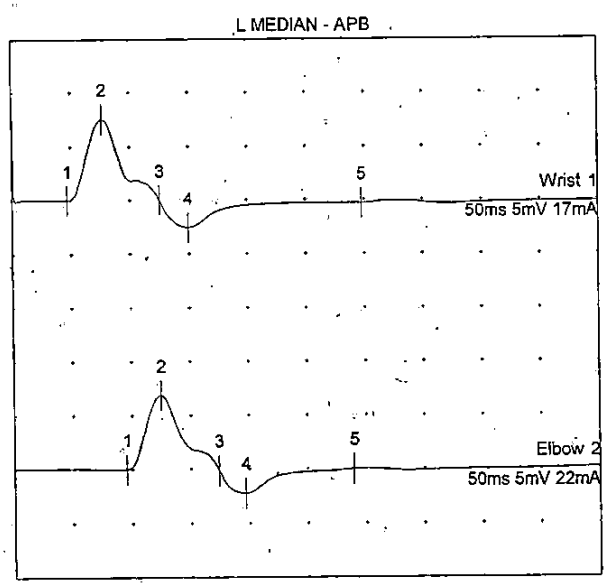
Sensory NCS

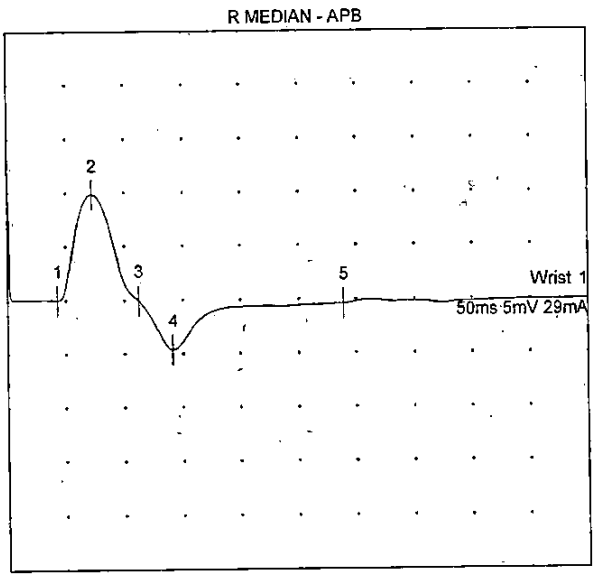
Nerve / Sites	Lat. 2 ms	Lat. ms	Amp.1-2 µV	Amp.2-3 µV	Dur. ms	Area µVms
R MEDIAN - Ortho_radial						
Index	3.70	3.18	9.4	8.6	1.88	10.0
Middle	3.91	3.18	13.9	14.7	1.46	10.5
Thumb Median	3.28	2.71	8.7	17.9	1.77	9.1
Thumb Radial	2.81	2.24	8.2	18.8	1.72	8.6
L MEDIAN - Ortho_radial						
Index	3.70	2.81	9.3	13.4	1.93	10.7
Middle	3.70	2.97	18.1	24.4	1.46	15.0
Thumb Median	3.18	2.50	21.1	28.9	1.56	17.8
Thumb Radial	3.28	2.50	8.0	21.5	1.61	11.3
L ULNAR - Ortho - V						
V	3.28	2.66	2.8	8.3	1.35	4.1
IV	3.28	2.71	2.7	6.7	1.46	3.3
R ULNAR - Ortho - V						
V	3.18	2.45	6.4	5.9	1.51	4.5
IV	3.13	2.50	5.2	4.8	1.30	4.0

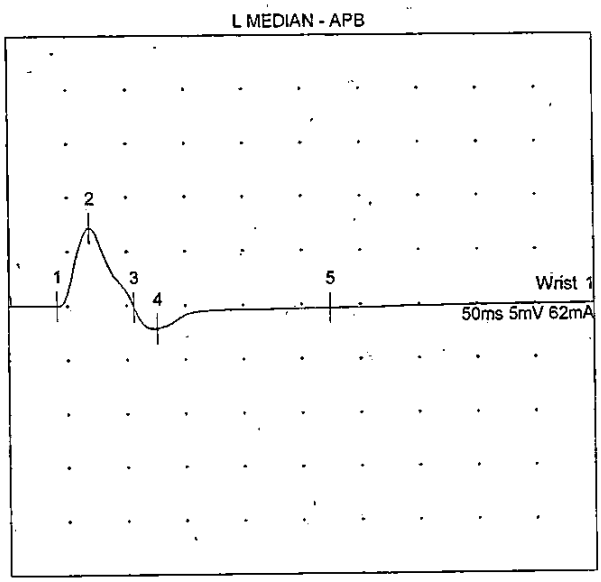


Motor NCS

Nerve / Sites	Lat. ms	Amp.1-2 mV	Dur. ms	Area mVms	Amp.1-2 %	Dur. %	Area %	Dist. cm	Vel. m/s
L MEDIAN - APB									
Wrist	4.69	7.6	7.86	25.6	100	100	100	8	
Elbow	9.53	6.9	7.86	24.4	91	100	95	26	53.7
R MEDIAN - APB									
Wrist	4.27	9.9	6.93	34.7	100	100	100	8	
L MEDIAN - APB									
Wrist	4.11	7.2	6.51	23.1	100	100	100	821	

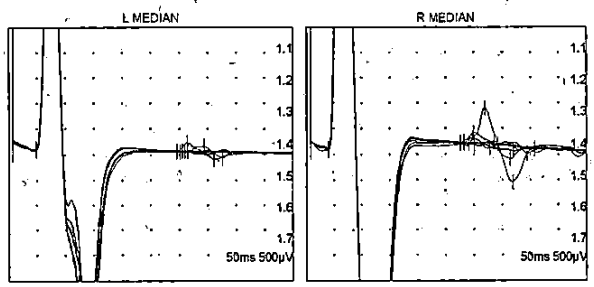






F Wave

Nerve	Min F Lat ms	Max F Lat ms	Rng F Lat ms	% F %	F Ratio
L MEDIAN	29.48	31.46	1.98	100	2.47
R MEDIAN	27.60	32.81	5.21	71.4	2.86



Needle EMG

EMG Summary Table									
	Spontaneous					MUAP			Recruitment
	IA	Fib	PSW	Fasc	H.F.	Amp	Dur.	PPP	Pattern
L. TRICEPS	N	None	None	None	None	N	N	N	Reduced

Galloway, Stephen
Male
14.06.1965 (58 Years)

Vent. rate 94 BPM
PR interval 172 ms
QRS duration 86 ms
QT/QTc-Baz 366/457 ms
P-R-T axes 55 59 51

Patient ID: 1406650854

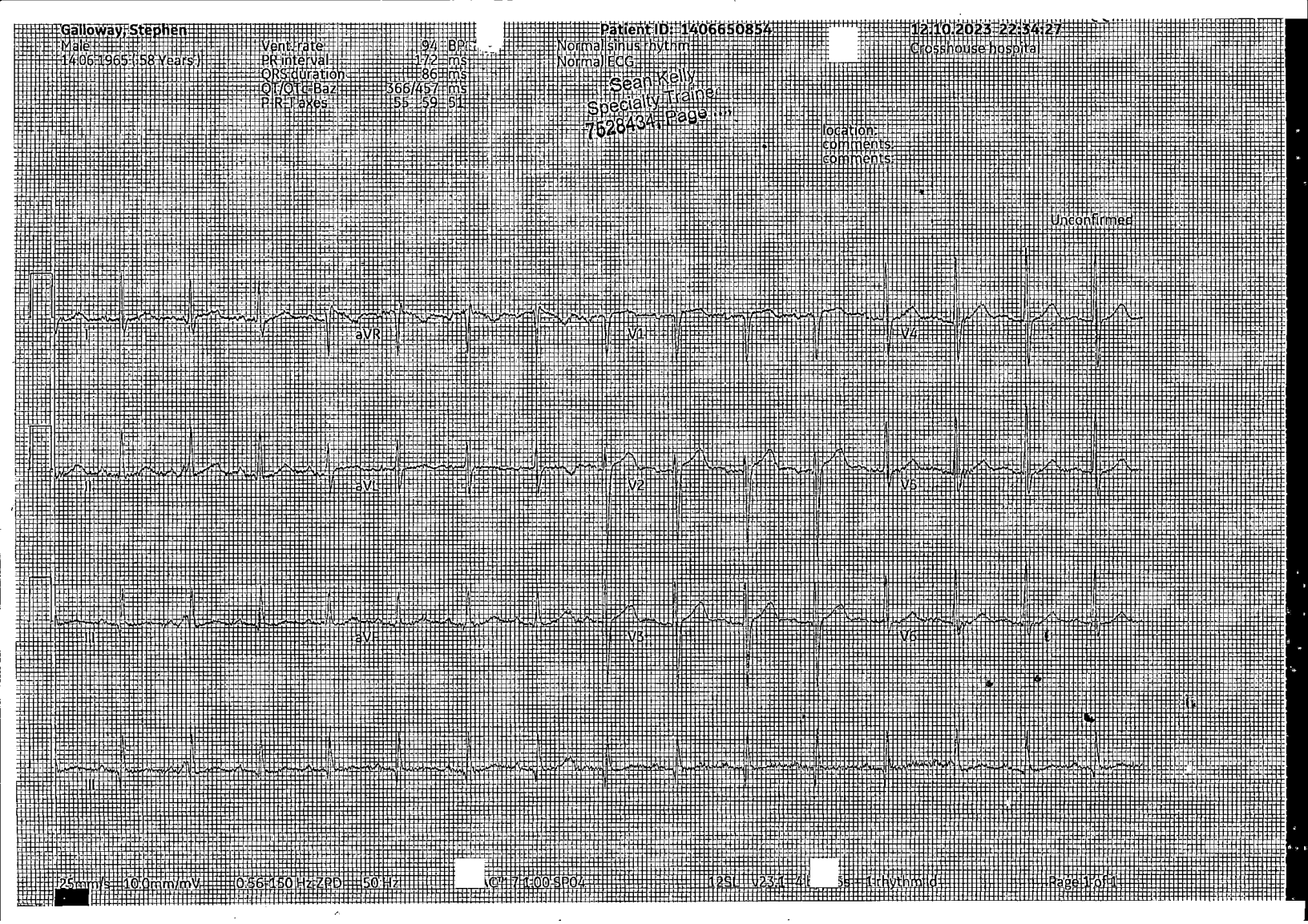
Normal sinus rhythm
Normal ECG

Sean Kelly
Specialty Trainee
7528434, Page ...

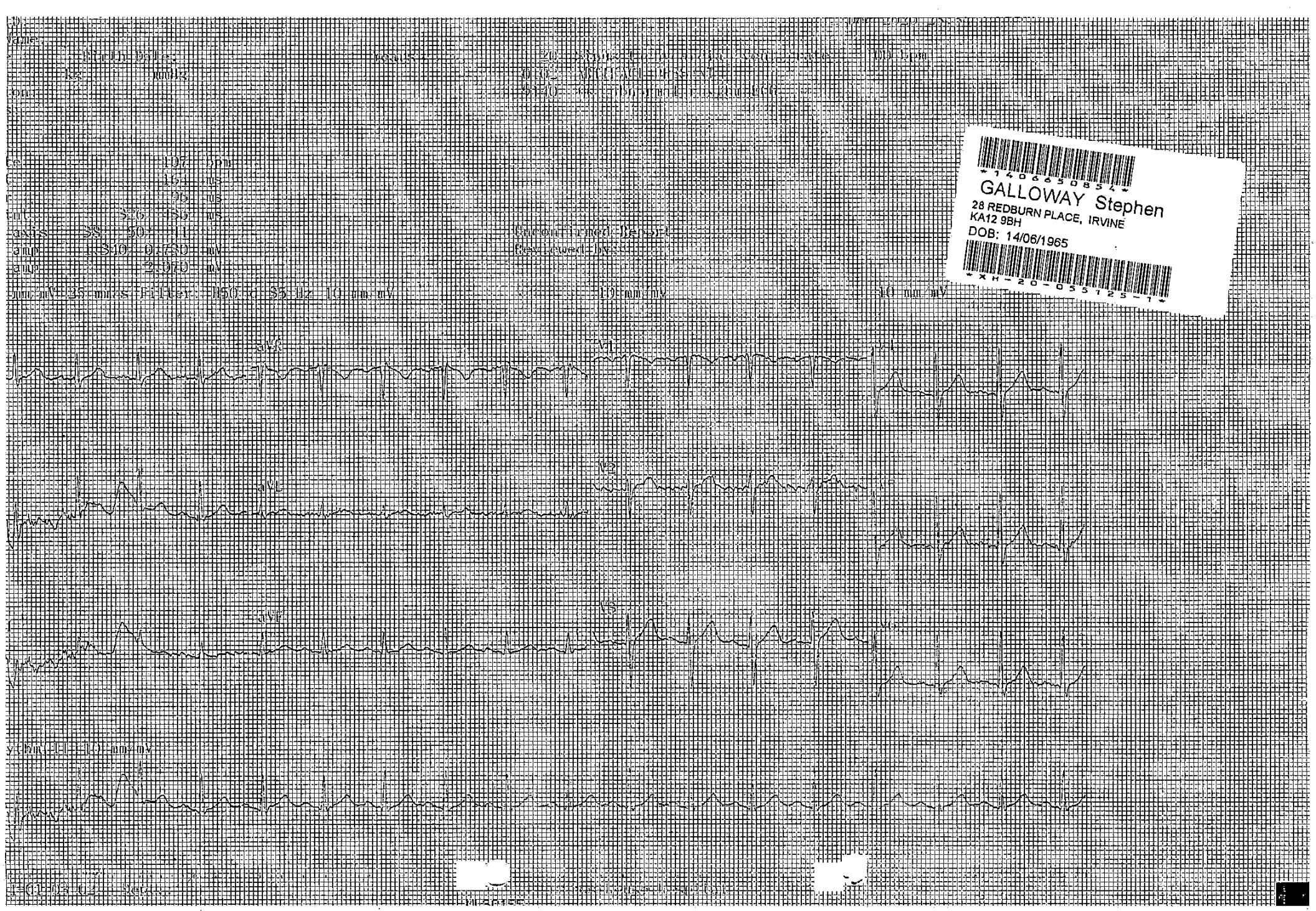
location:
comments:
comments:

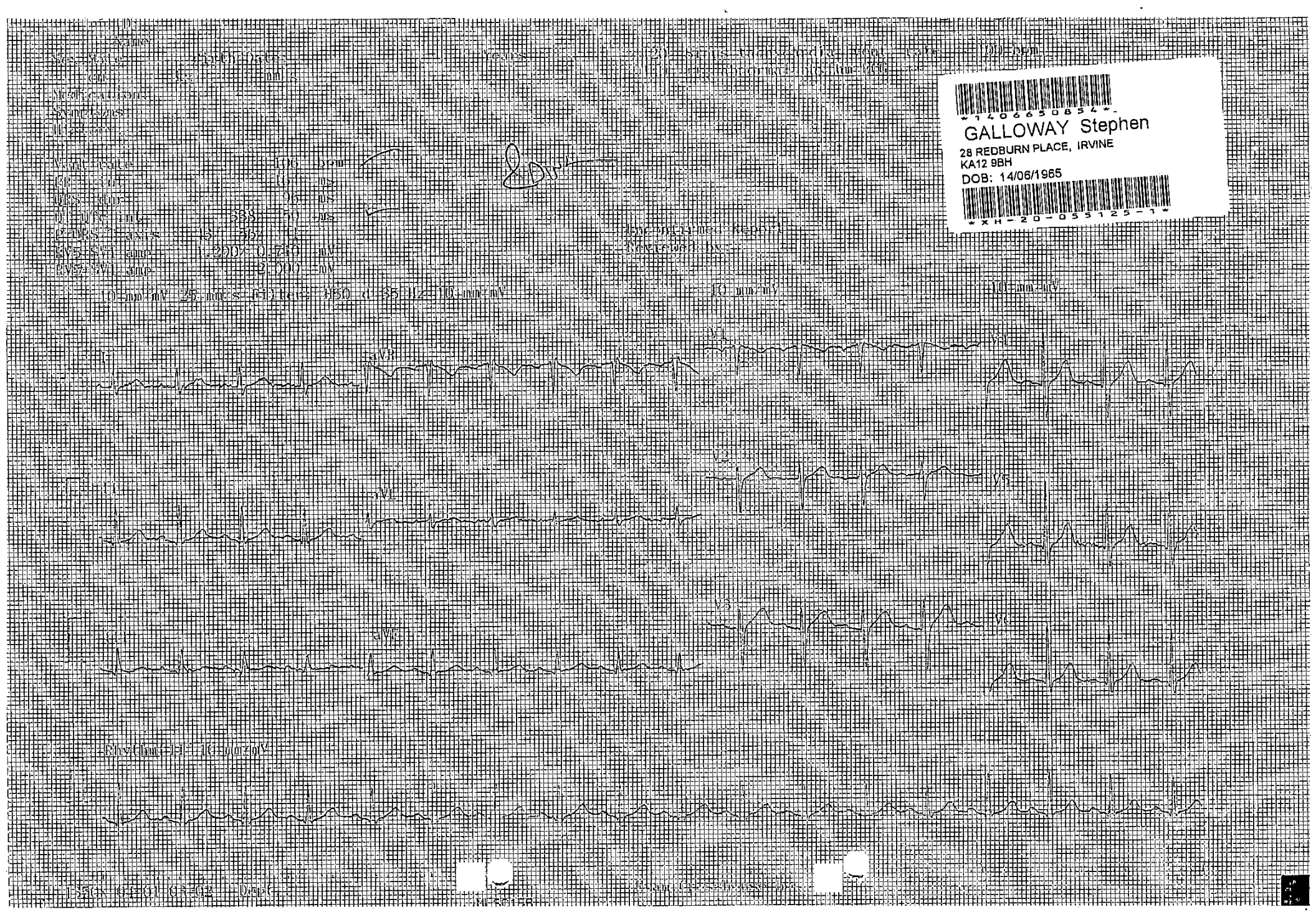
12.10.2023 22:34:27
Crosshouse hospital

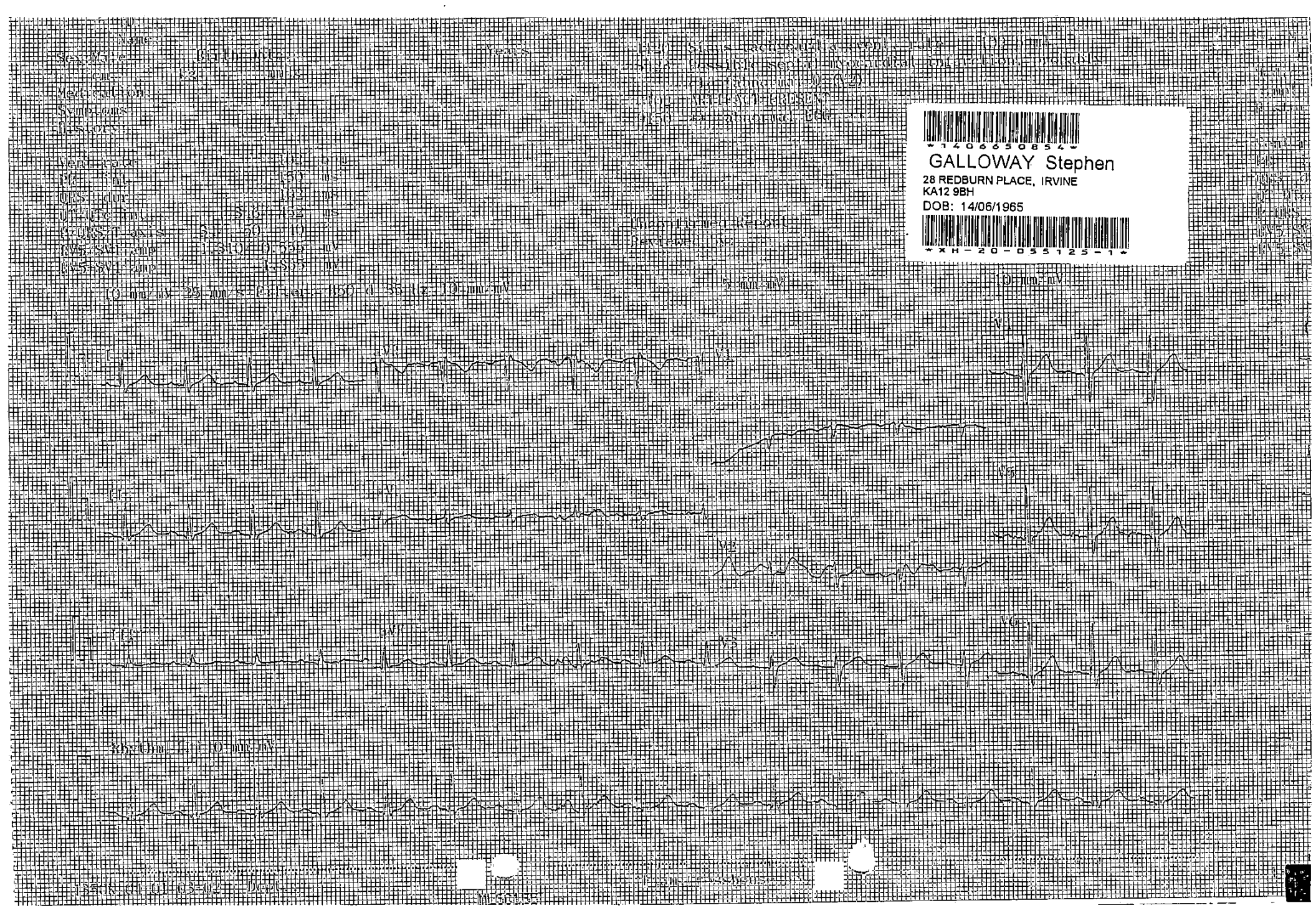
Unconfirmed

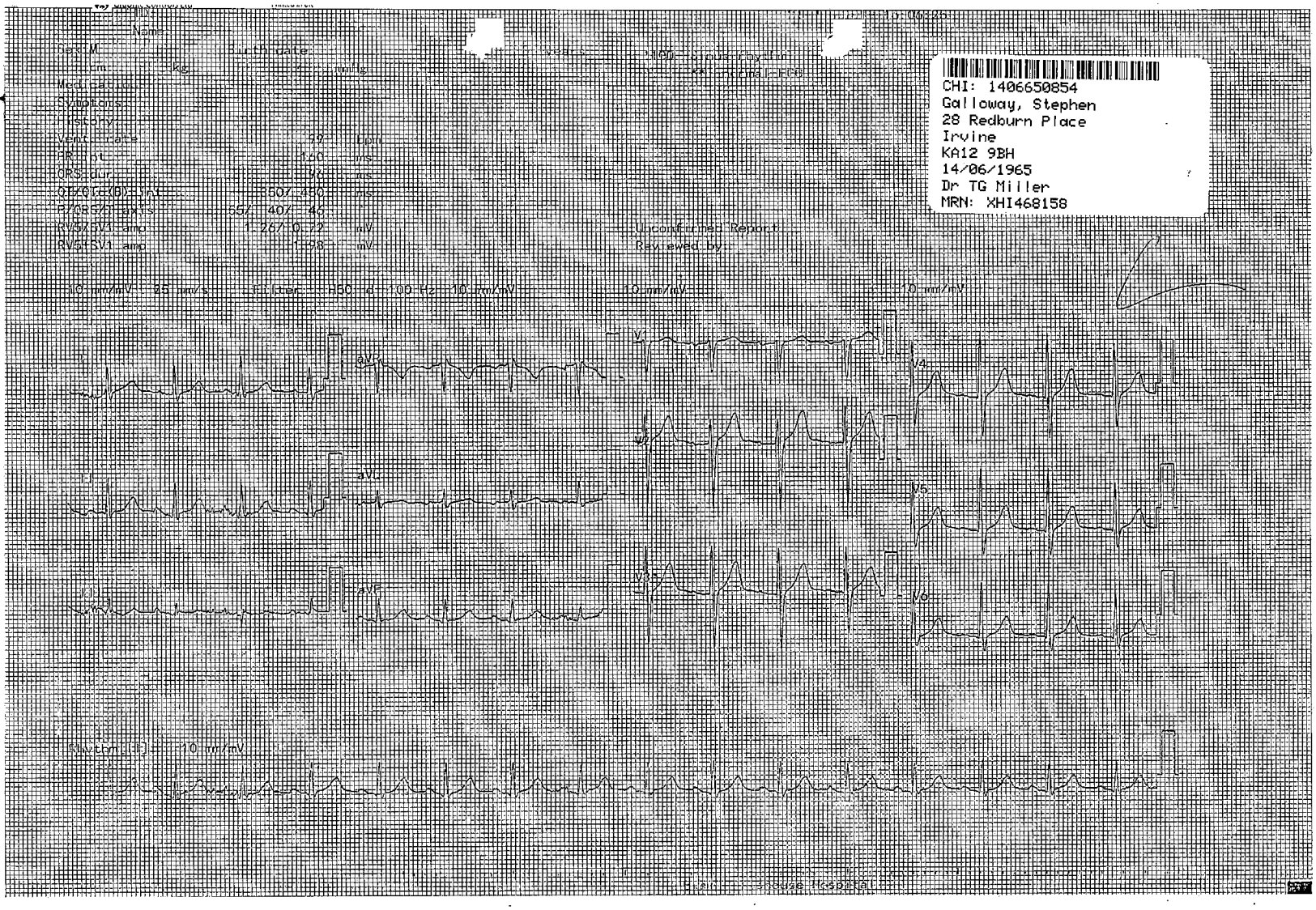


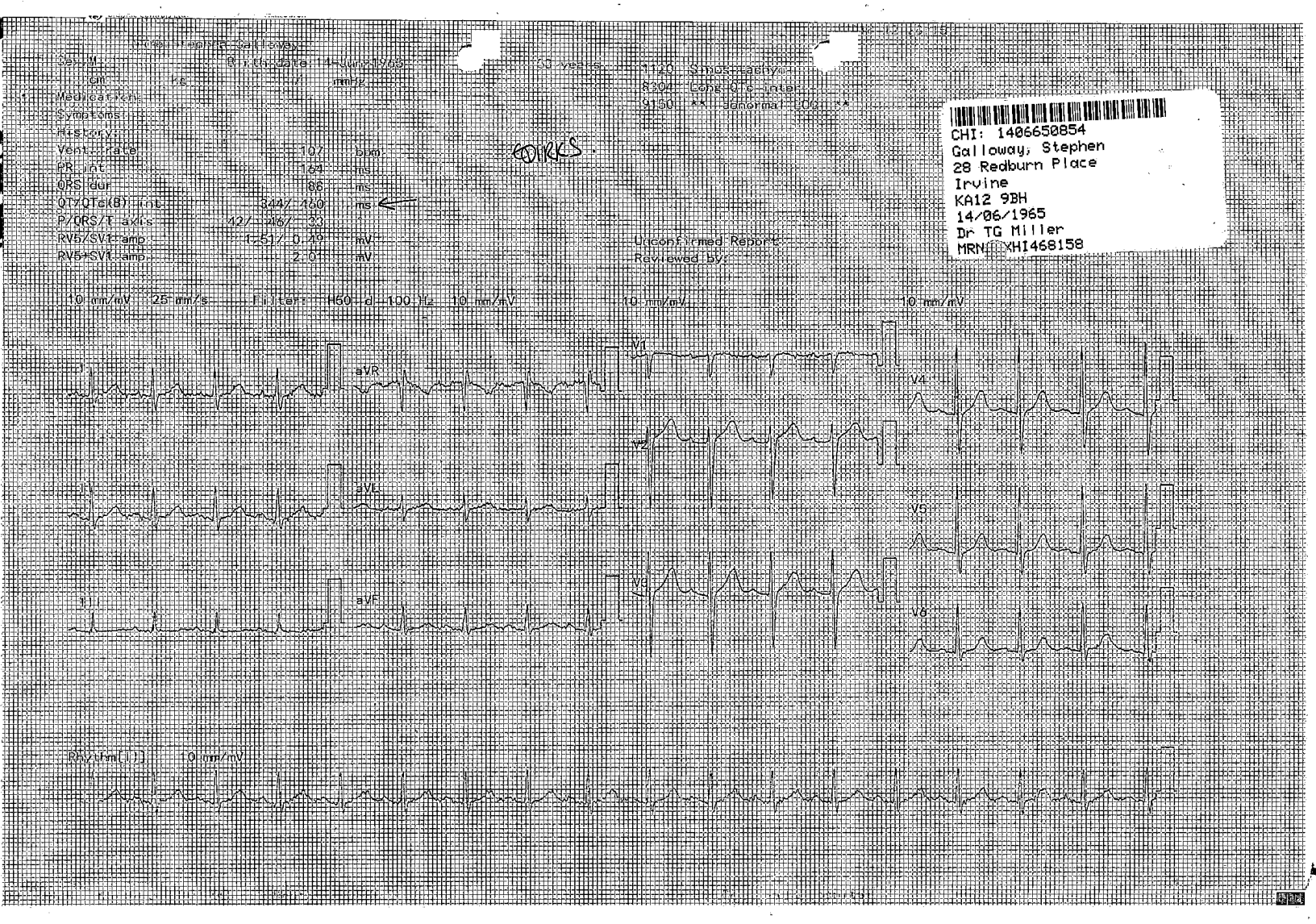
25mm/s 10.0mm/mV 0.56-150 Hz-ZPD 50 Hz [illegible]C* 7.1.00-SP04 12SL V23.1 4[illegible]5s (1)rhythm.id Page 1 of 1


GALLOWAY Stephen
28 REDBURN PLACE, IRVINE
KA12 9BH
DOB: 14/06/1965
Unconfirmed Report
aVR
V1
aVL
V2
aVF
V5
V6


GALLOWAY Stephen
28 REDBURN PLACE, IRVINE
KA12 9BH
DOB: 14/06/1965
aVR
V1
V4
aVL
V2
V5
aVF
V3
V6


1406650854
GALLOWAY Stephen
28 REDBURN PLACE, IRVINE
KA12 9BH
DOB: 14/06/1965
XH-20-055125-1


Name
Birthdate
Years
Unconfirmed Report
Reviewed by
CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158
10 mm/mV
25 mm/s
Filter
50 Hz
100 Hz
I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6
Rhythm (II)


Galloway, Stephen
Male
14-June-1965
55 years
Sinus rhythm
Consider inferior infarct
** Abnormal ECG **
CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158
Unconfirmed Report
Reviewed by:
Ventricular rate 107 bpm
PR interval 164 ms
QRS duration 86 ms
QT/QTc(B) interval 344/460 ms
P/QRS/T axes 42 46 33
RV5/SV1 amp 1.51 0.49 mV
RV5+SV1 amp 2.01 mV
10 mm/mV 25 mm/s Filter: H60 d 100 Hz
I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6
Rhythm[II] 0 mm/mV

Grosshouse Hospital
Kilmarnock

Ward:
Telephone:

EXERCISE STRESS TEST REPORT

Patient Name: Galloway, Stephen
Patient ID: 1406650854
Height:
Weight:

DOB: 14/06/1965
Age: 49yrs
Gender: Male
Race: Caucasian

Study Date: 22/01/2015
Test Type: Treadmill Stress Test
Protocol: BRUCE

Referring Physician: Dr Chung
Attending Physician:
Technician: Paul Fitzsimmons

Medications:

Medical History:

Reason for Exercise Test:
Chest Paun

Exercise Test Summary

Phase Name	Stage Name	Time in Stage	Speed (mph)	Grade (%)	HR (bpm)	BP (mmHg)	Comment
PRETEST	SUPINE	00:48	0.60	0.00	106	136/94	
EXERCISE	STAGE 1	03:00	1.70	10.00	141	160/80	
	STAGE 2	03:00	2.50	12.00	125	168/84	
	STAGE 3	03:00	3.40	14.00	158	188/80	
	STAGE 4	03:00	4.20	16.00	169	188/80	920 Slight SOB
	STAGE 5	00:01	4.20	16.00	169		
RECOVERY		05:20	0.00	0.00	102	142/80	

Patient exercised according to the BRUCE for 12:00 min:s, achieving a work level of Max. METS: 13.40. The resting heart rate of 85 bpm rose to a maximal heart rate of 171 bpm. This value represents 100 % of the maximal, age-predicted heart rate. The resting blood pressure of 136/94 mmHg, rose to a maximum blood pressure of 188/80 mmHg. The exercise test was stopped due to Target heart rate achieved.

Interpretation

Summary: Resting ECG: normal. HR Response to Exercise: appropriate. BP Response to Exercise: normal resting BP = appropriate response. Chest Pain: none. Arrhythmias: none. ST Changes: none. Overall impression: Normal stress test.

Conclusions

No chest pain.
Slight SOB.
THR reached.
Normal test.

Physician: Technician:

Tabular Summary

Galloway, Stephen — Crosshouse Hospital

Patient ID: 1406650854

22.01.2015 10:41:57 — Male — 49yrs — Caucasian

Meds:

Test Reason: Chest Paun

Medical History:

Ref. MD: Dr Chung — Ordering MD:

Technician: Paul Fitzsimmons — Test Type: Treadmill Stress Test

Comment:

BRUCE - Total Exercise Time: 12:00

Max HR: 171 bpm - 100% of max predicted 171 bpm

Max BP: 188/80 - Maximum Workload: 13.40 METS

Max ST Level: 0.95 mm in III, EXERCISE STAGE 4 9:59

Reasons for Termination: Target heart rate achieved

Summary: Resting ECG: normal - HR Response to Exercise: appropriate - BP Response to Exercise: normal resting BP - appropriate response - Chest Pain: none - Arrhythmias: none - ST Changes: none - Overall impression: Normal stress test

Conclusion: No chest pain.

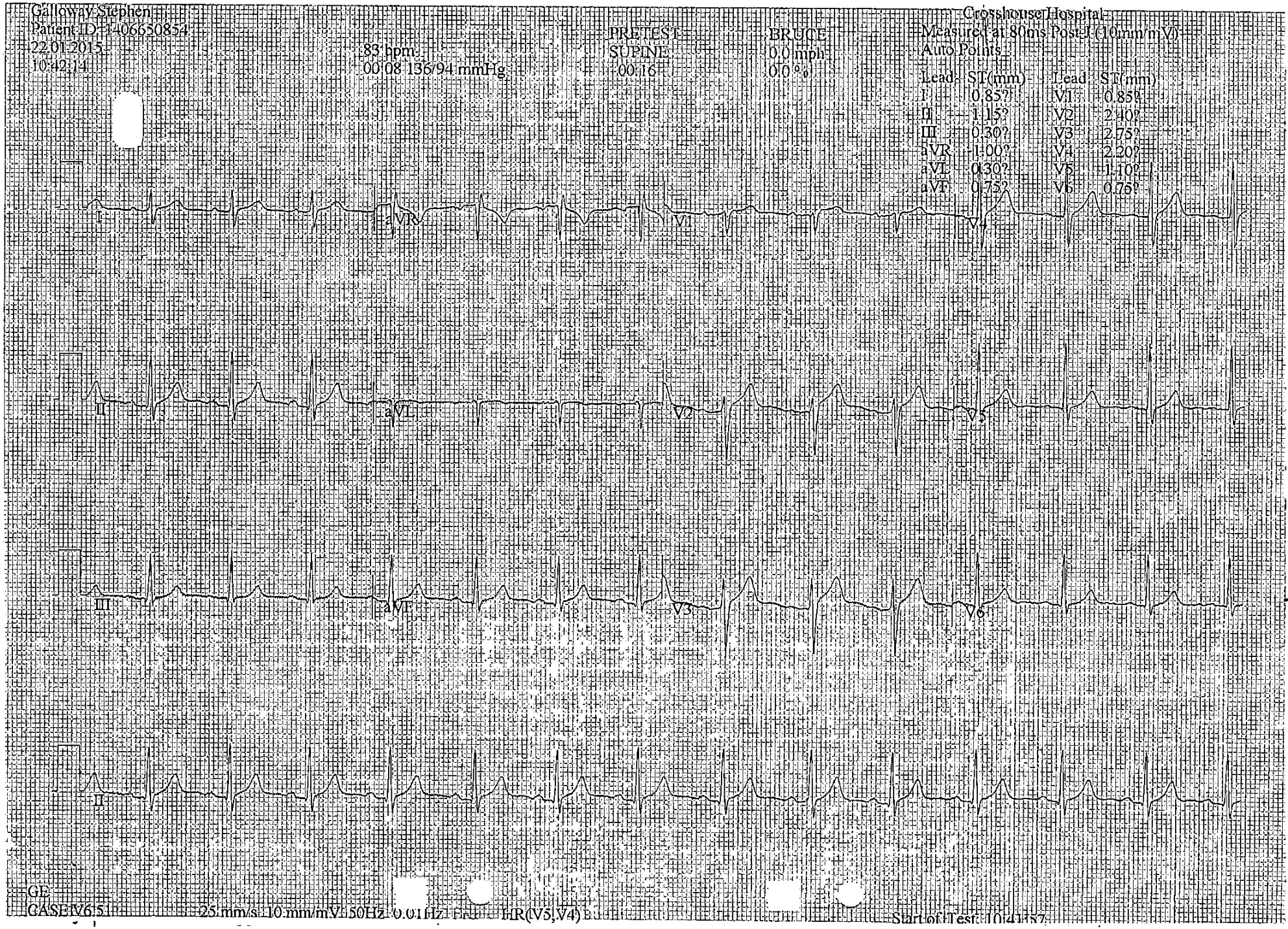
Slight SOB

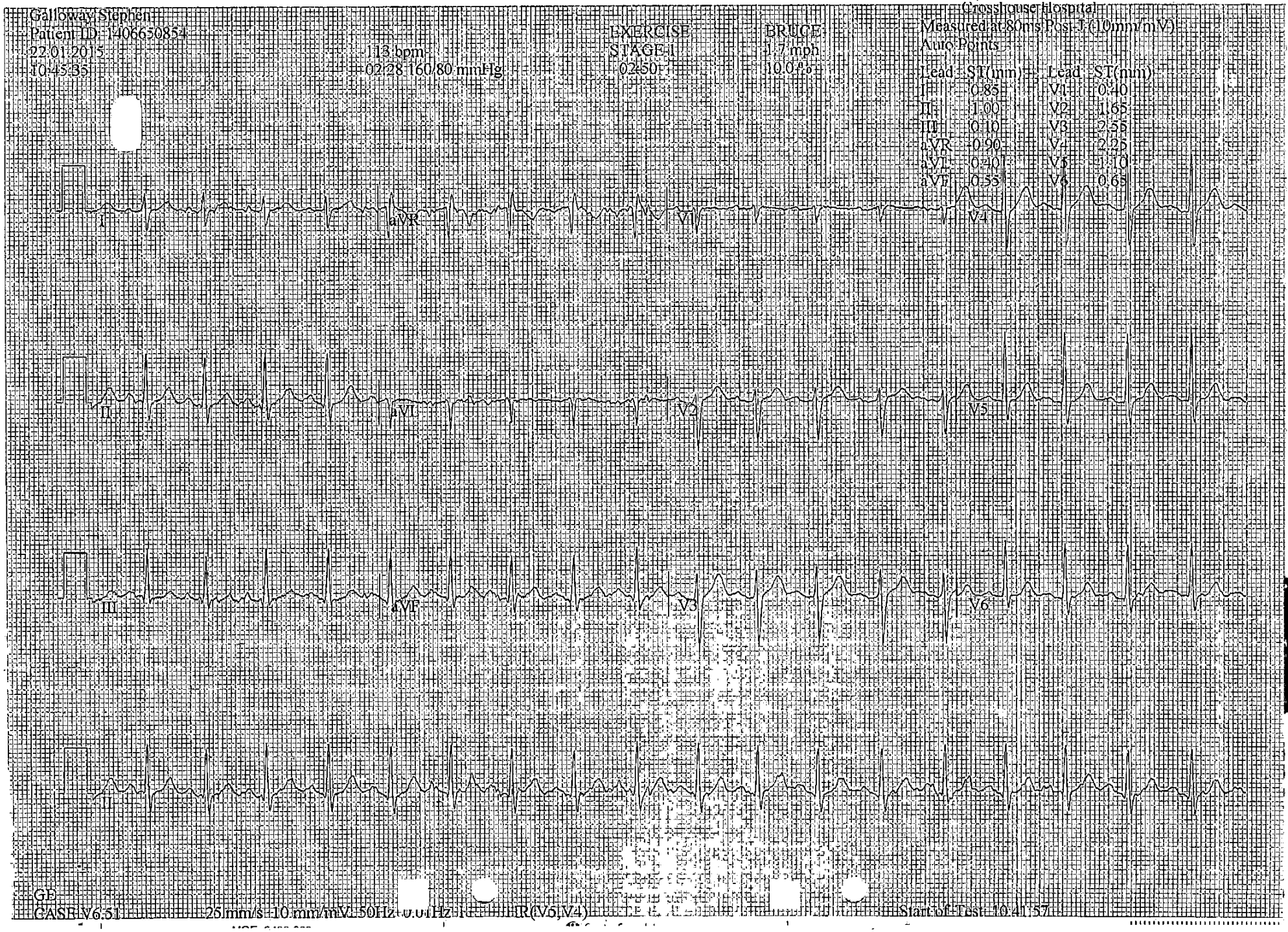
THR reached.

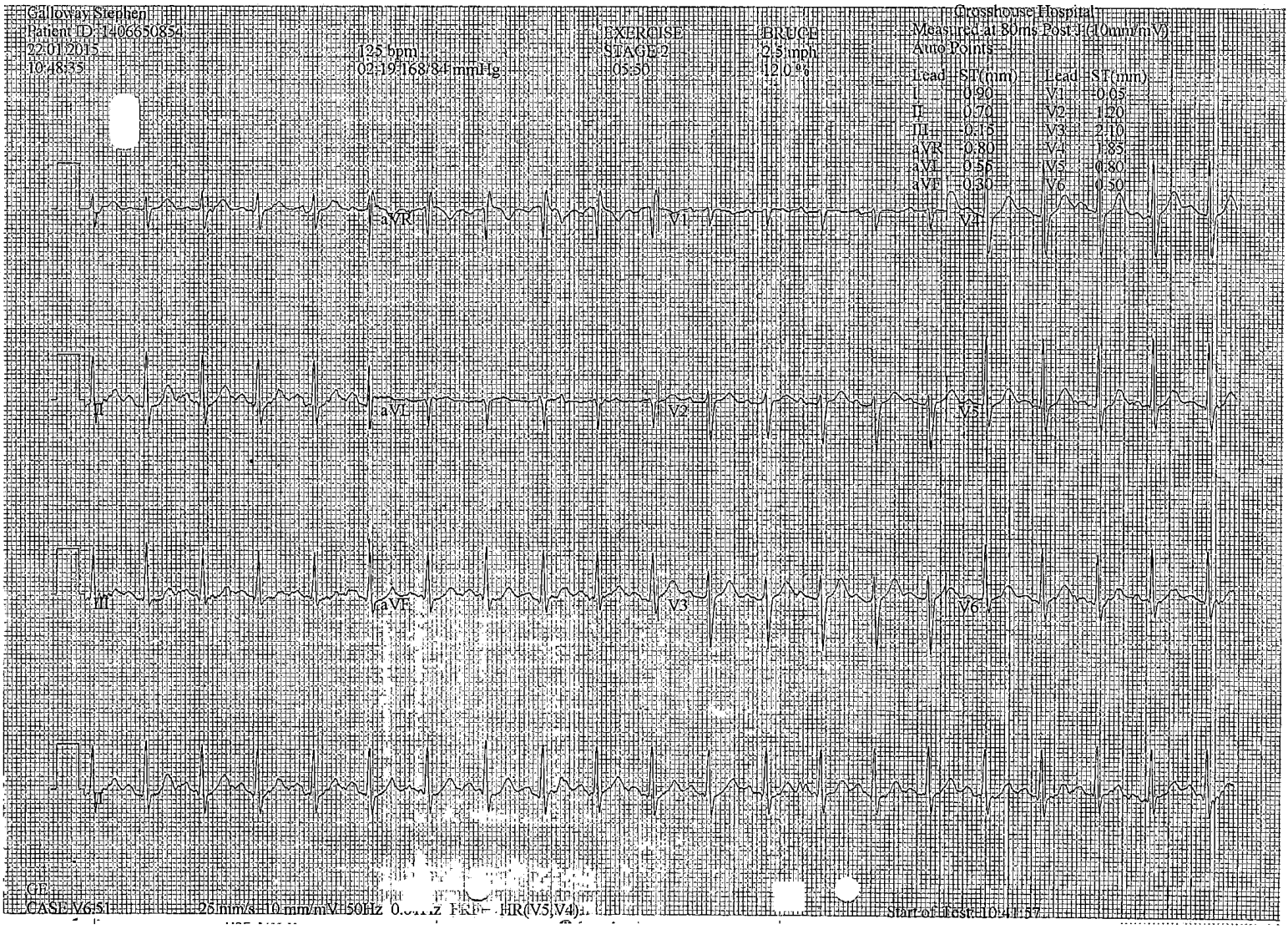
Normal test.

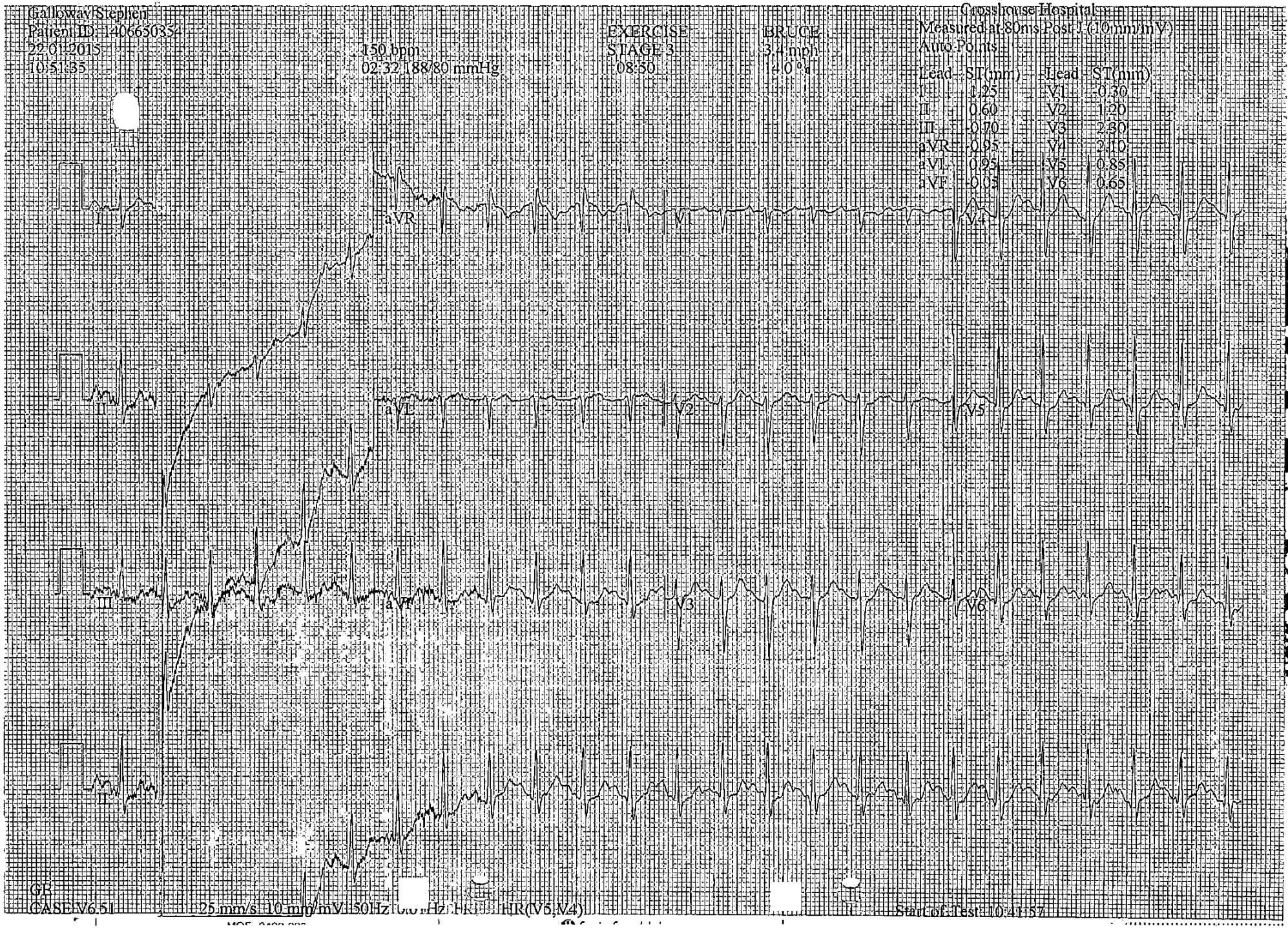
Location Number: * 0 *

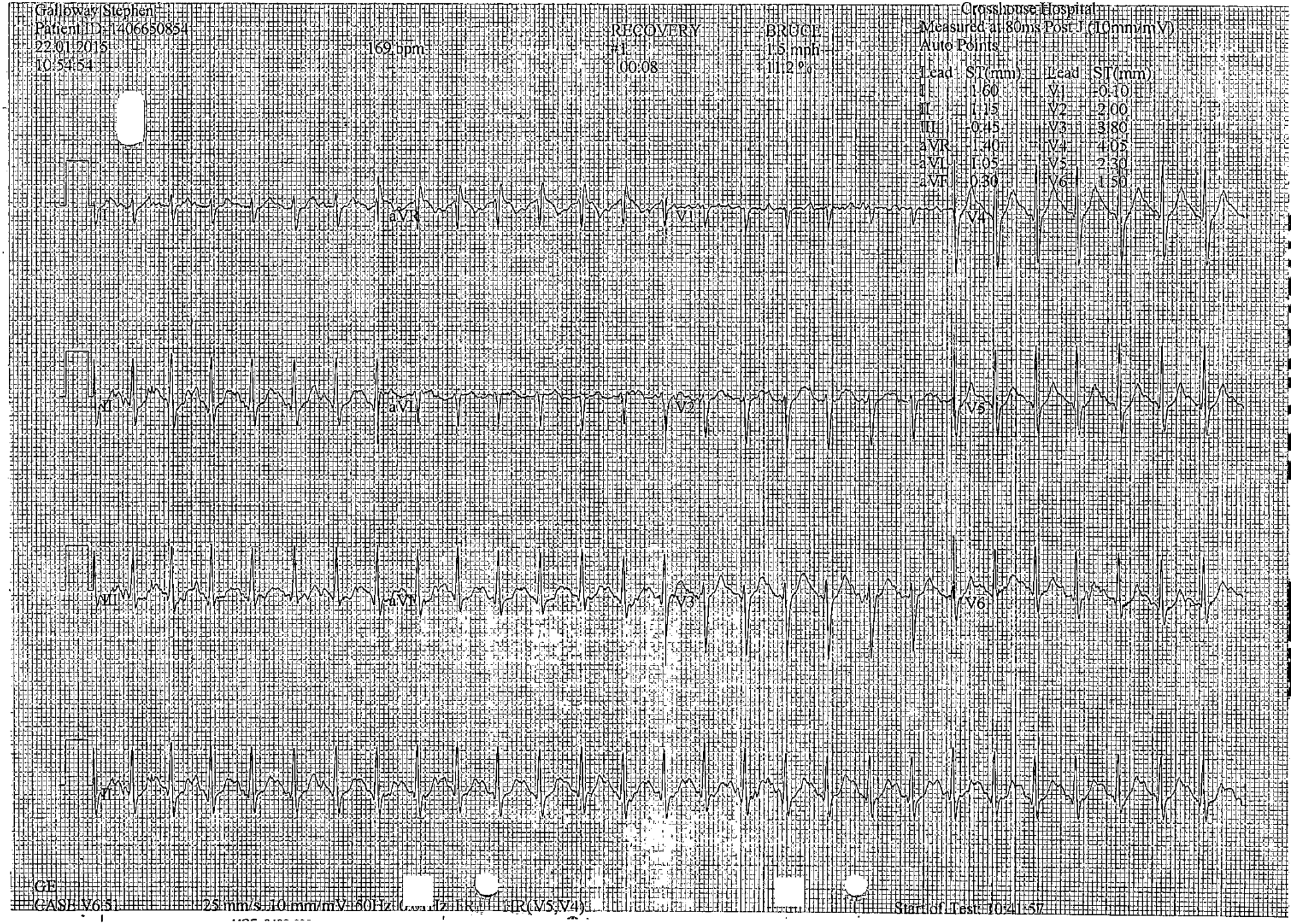
Phase Name	Stage Name	Time in Stage	Speed (mph)	Grade (%)	Workload (METS)	HR (bpm)	BP (mmHg)	RPP (*100)	VE (/min)	ST Level III (mm)	Comment
PRETEST	SUPINE	00:48	0.60	0.00	1.1	106	136/94	144	0	0:25	
EXERCISE	STAGE 1	03:00	1.70	10.00	4.6	111	160/80	177	0	0:10	
	STAGE 2	03:00	2.50	12.00	7.0	125	168/84	210	0	0:15	
	STAGE 3	03:00	3.40	14.00	10.1	133	188/80	287	0	0:60	
	STAGE 4	03:00	4.20	16.00	13.4	169	188/80	317	0	0:35	9:20 Slight SOB
	STAGE 5	00:01	4.20	16.00	13.4	169			0	0:20	
RECOVERY		05:20	0.00	0.00	1.0	112	142/80	159	0	0:35	

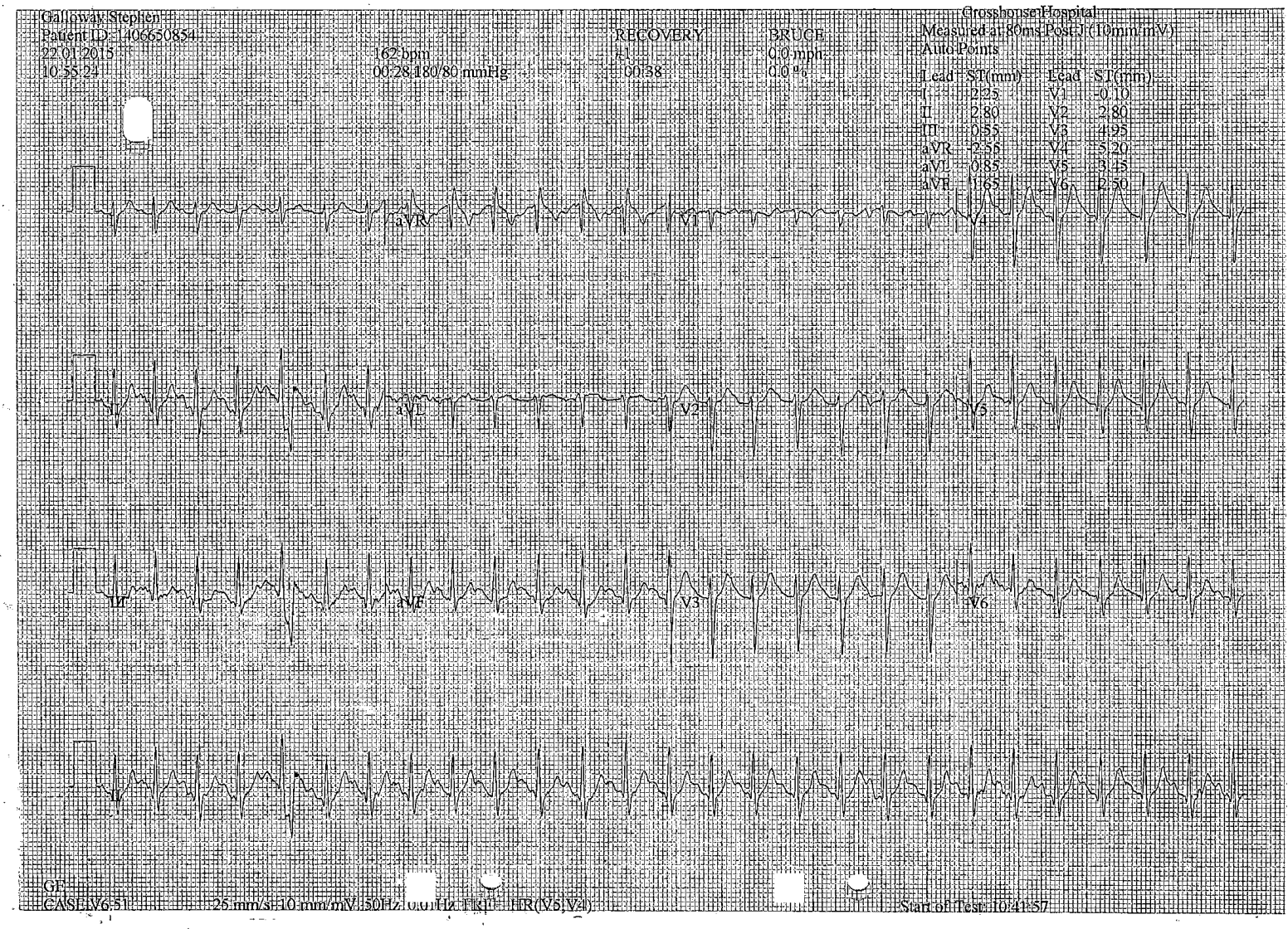

Galloway,Stephen
Patient ID 1406650854
22.01.2015
10:42:14
83 bpm
00:08 136/94 mmHg
PRETEST
SUPINE
00:16
BRUCE
0.0 mph
0.0 %
Crosshouse Hospital
Measured at 80ms Post J (10mm/mV)
Auto Points
Lead ST(mm) Lead ST(mm)
I 0.85? V1 0.85?
II 1.15? V2 2.40?
III 0.30? V3 2.75?
aVR 1.00? V4 2.20?
aVL 0.30? V5 1.10?
aVF 0.75? V6 0.75?
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II
GE
CASE V6.5.1
25 mm/s 10 mm/mV 50Hz 0.01Hz Filter
HR(V5,V4)
Start of Test 10:41:57

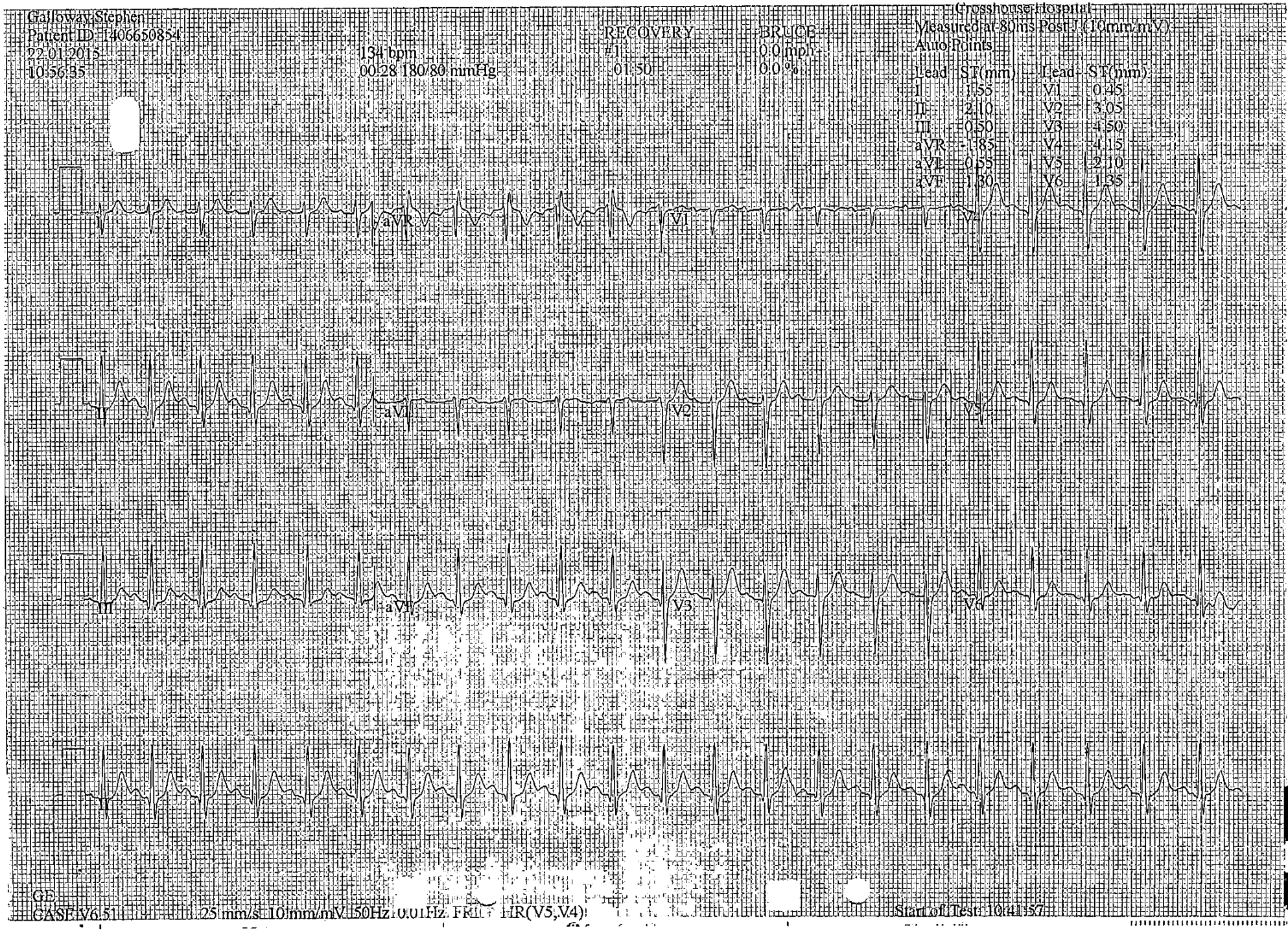

Galloway,Stephen
Patient ID: 1406650854
22.01.2015
10:45:35
113 bpm
02:28 160/80 mmHg
EXERCISE
STAGE I
02:50
BRUCE
1.7 mph
10.0 %
Crosshouse Hospital
Measured at 80ms Post J (10mm/mV)
Auto Points
Lead ST(mm) Lead ST(mm)
I 0.85 V1 0.40
II 1.00 V2 1.65
III 0.10 V3 2.55
aVR -0.90 V4 2.25
aVL 0.40 V5 1.10
aVF 0.55 V6 0.65
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II
GE
CASE V6.51
25 mm/s 10 mm/mV 50Hz 0.01Hz
R(V6,V4)
Start of Test 10:41:57

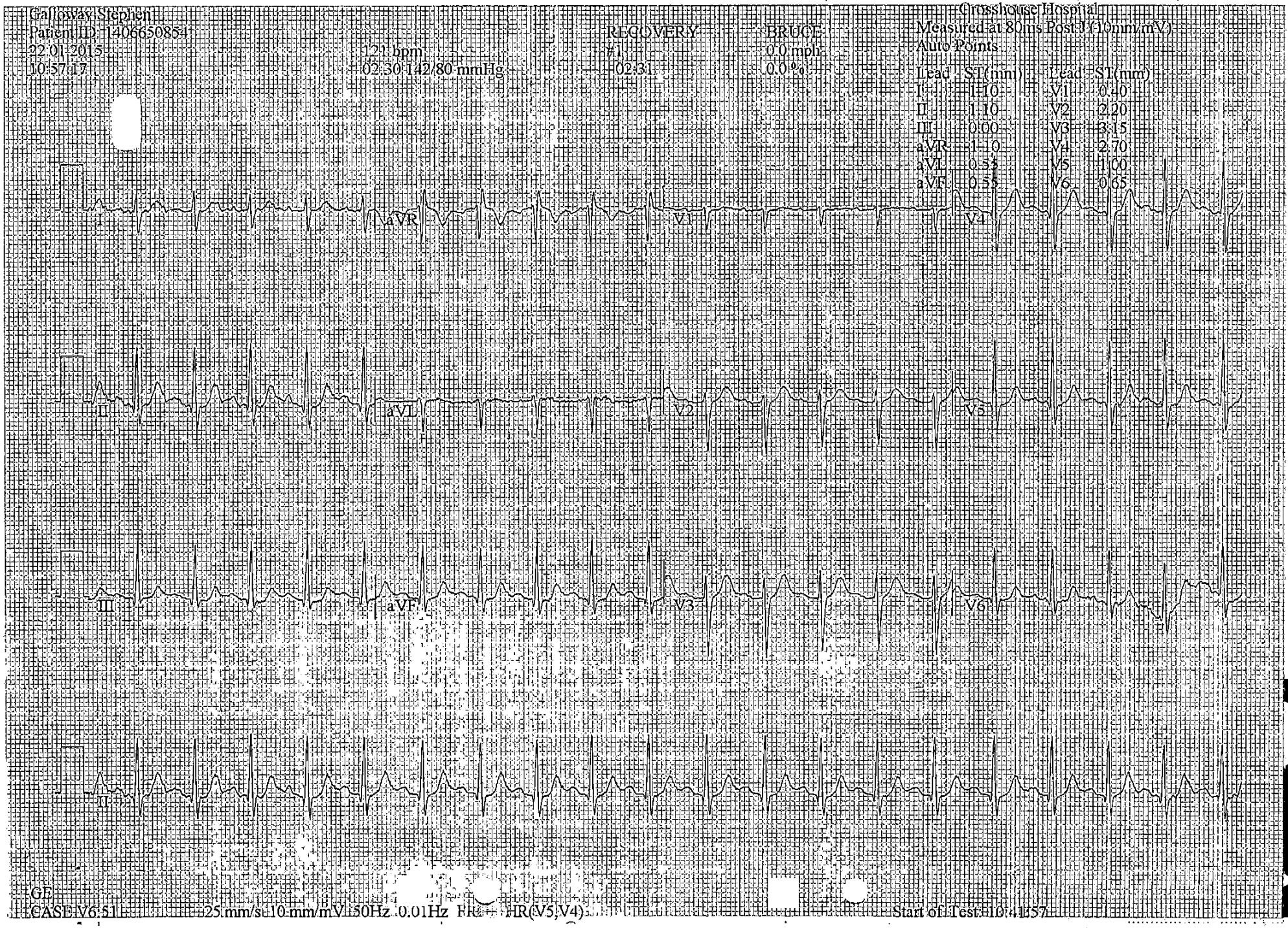

Galloway,Stephen
Patient ID:1406650854
22/01/2015
10:48:35
125 bpm
02-19/168/84 mmHg
EXERCISE
STAGE 2
05:30
BRUCE
2.5 mph
12.0 %
Crosshouse Hospital
Measured at 80ms Post J (10mm/mV)
Auto Points
Lead ST(mm) Lead ST(mm)
I 0.90 V1 0.05
II 0.70 V2 1.20
III -0.15 V3 2.10
aVR -0.80 V4 1.85
aVL 0.55 V5 0.80
aVF 0.30 V6 0.50
I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6
GE
CASE-V6:S1 25 mm/s 10 mm/mV 50Hz
HR(V5,V4)
Start of Test: 10:41:57

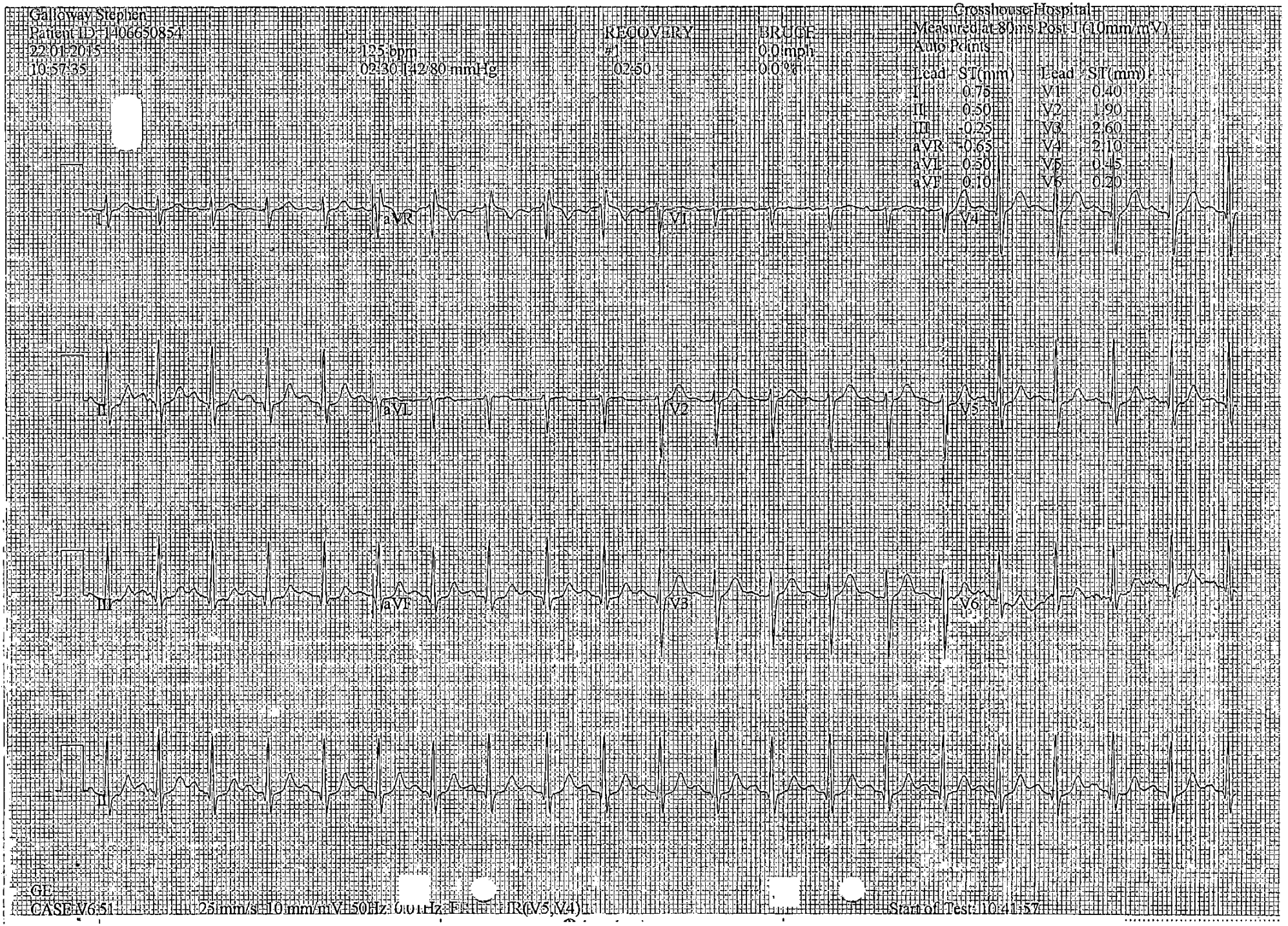

Galloway,Stephen
Patient ID: 1406650354
22/01/2015
10:51:35
150 bpm
02:32 188/80 mmHg
EXERCISE
STAGE 3
08:50
BRUCE
3.4 mph
14.0 %
Crosshouse Hospital
Measured at 80ms Post J (10mm/mV)
Auto Points
Lead ST(mm) Lead ST(mm)
I 1.25 V1 -0.30
II 0.60 V2 1.20
III -0.70 V3 2.30
aVR -0.95 V4 2.10
aVL 0.95 V5 0.85
aVF -0.05 V6 0.65
I
aVR
V1
II
aVL
V2
V5
III
aVF
V3
V6
II
GE
CASE:V6.51
25 mm/s 10 mm/mV 50Hz
HR(V5,V4)
Start of Test 10:41:57

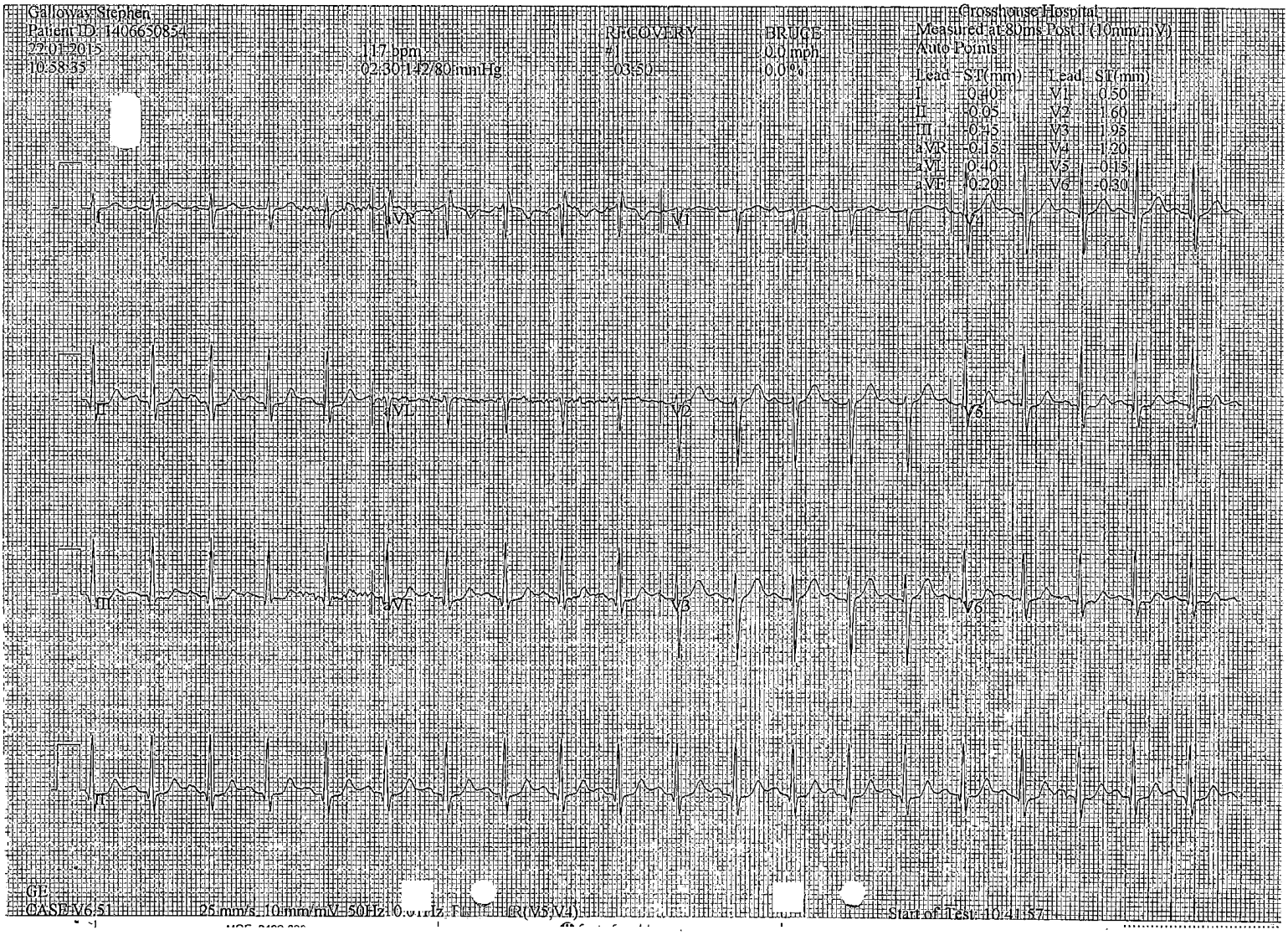

Galloway Stephen
Patient ID: 1406650854
22.01.2015
10:54:54
169 bpm
RECOVERY
#1
00:08
BRUCE
1.5 mph
11.2 %
Crosshouse Hospital
Measured at 80ms Post J (10mm/mV)
Auto Points
Lead ST(mm) Lead ST(mm)
I 1.60 V1 -0.10
II 1.15 V2 2.00
III -0.45 V3 3.80
aVR -1.40 V4 4.05
aVL 1.05 V5 2.30
aVF 0.30 V6 1.50
I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6
GE
CASE V6.51
25 mm/s 10mm/mV 60Hz
R(V5,V4)
Start of Test 10:41:57

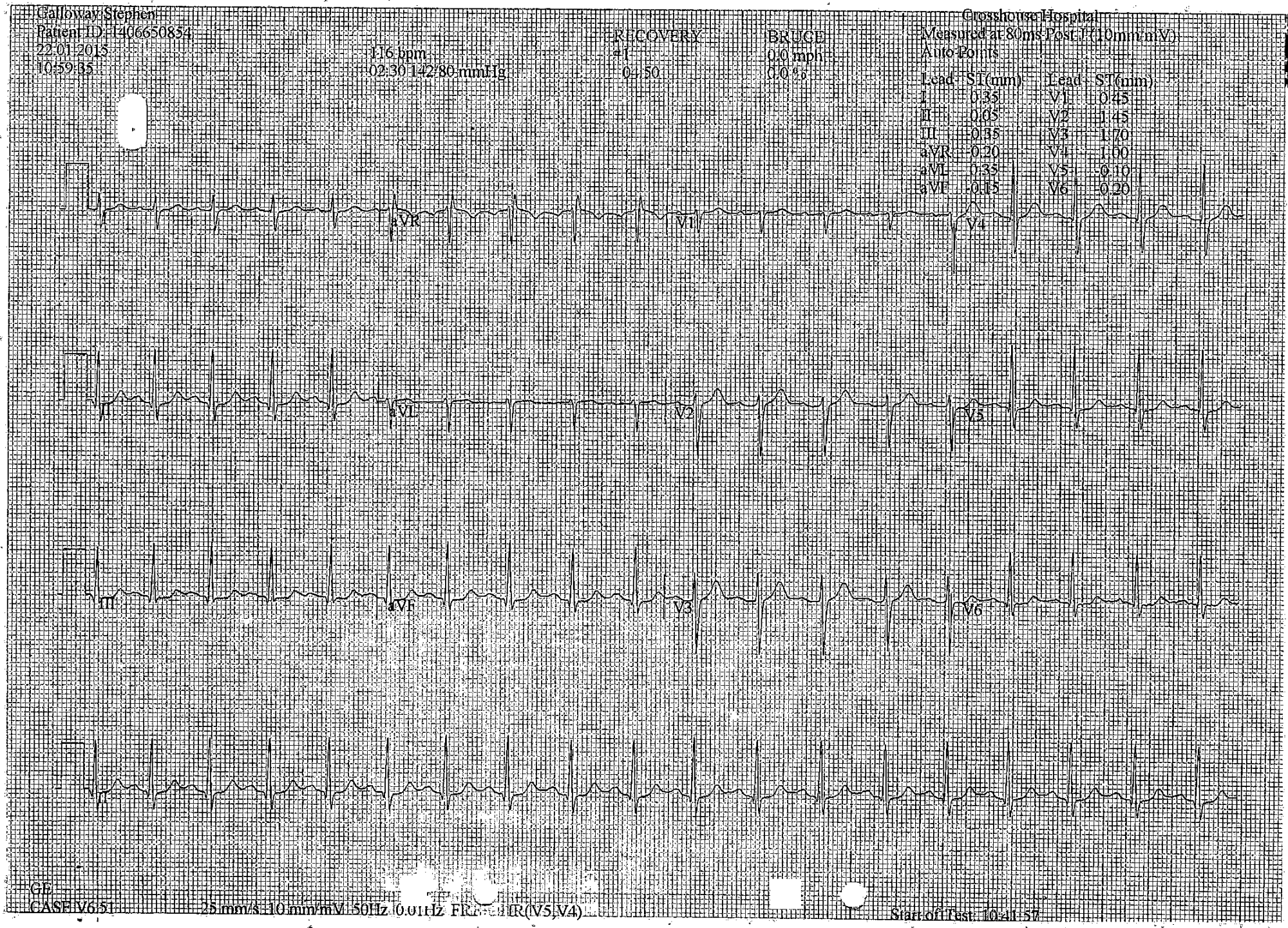

Galloway, Stephen
Patient ID: 1406650854
22.01.2015
10:55:24
162 bpm
00:28:18 80/80 mmHg
RECOVERY
#1
00:38
BRUCE
0.0 mph
0.0 %
Crosshouse Hospital
Measured at 80ms Post J (10mm/mV)
Auto Points
Lead ST(mm) Lead ST(mm)
I 2.25 V1 -0.10
II 2.80 V2 2.80
III 0.55 V3 4.95
aVR -2.55 V4 5.20
aVL 0.85 V5 3.15
aVF 1.65 V6 2.50
I
aVR
V1
II
aVL
V2
III
aVF
V3
V4
V5
V6
GE
CASE:V6.51
25 mm/s 10 mm/mV 50Hz 0.0 Hz TK10 HR(V5,V4)
Start of Test: 10:41:57


Galloway,Stephen
Patient ID: 1406650854
22.01.2015
10:56:35
134 bpm
00:28 180/80 mmHg
RECOVERY
#1
01:50
BRUCE
0.0 mph
0.0 %
Crosshouse Hospital
Measured at 80ms Post J (10mm/mV)
Auto Points
Lead ST(mm)
I -1.55
II -2.10
III -0.50
aVR 1.85
aVL 0.55
aVF 1.30
Lead ST(mm)
V1 0.45
V2 3.05
V3 4.50
V4 4.15
V5 2.10
V6 1.35
I
aVR
V1
II
aVL
V2
V5
III
aVF
V3
V6
II
GE
CASE V6.51
25 mm/s 10 mm/mV 50Hz 0.01Hz FR HR(V5,V4)
Start of Test: 10:41:57


Galloway,Stephen
PatientID 1406650854
22-01-2015
10:57:17
121 bpm
02:30 142/80 mmHg
RECOVERY
#1
02:31
BRUCE
0.0 mph
0.0 %
Crosshouse Hospital
Measured at 80ms Post J (10mm/mV)
Auto Points
Lead ST(mm) Lead ST(mm)
I -1.10 V1 0.40
II -1.10 V2 2.20
III 0.00 V3 3.15
aVR 1.10 V4 2.70
aVL 0.55 V5 1.00
aVF 0.55 V6 0.65
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II
GE
CASE V6.51
25 mm/s 10 mm/mV 50Hz .0.01Hz
HR(V5,V4)
Start of Test 10:41:57

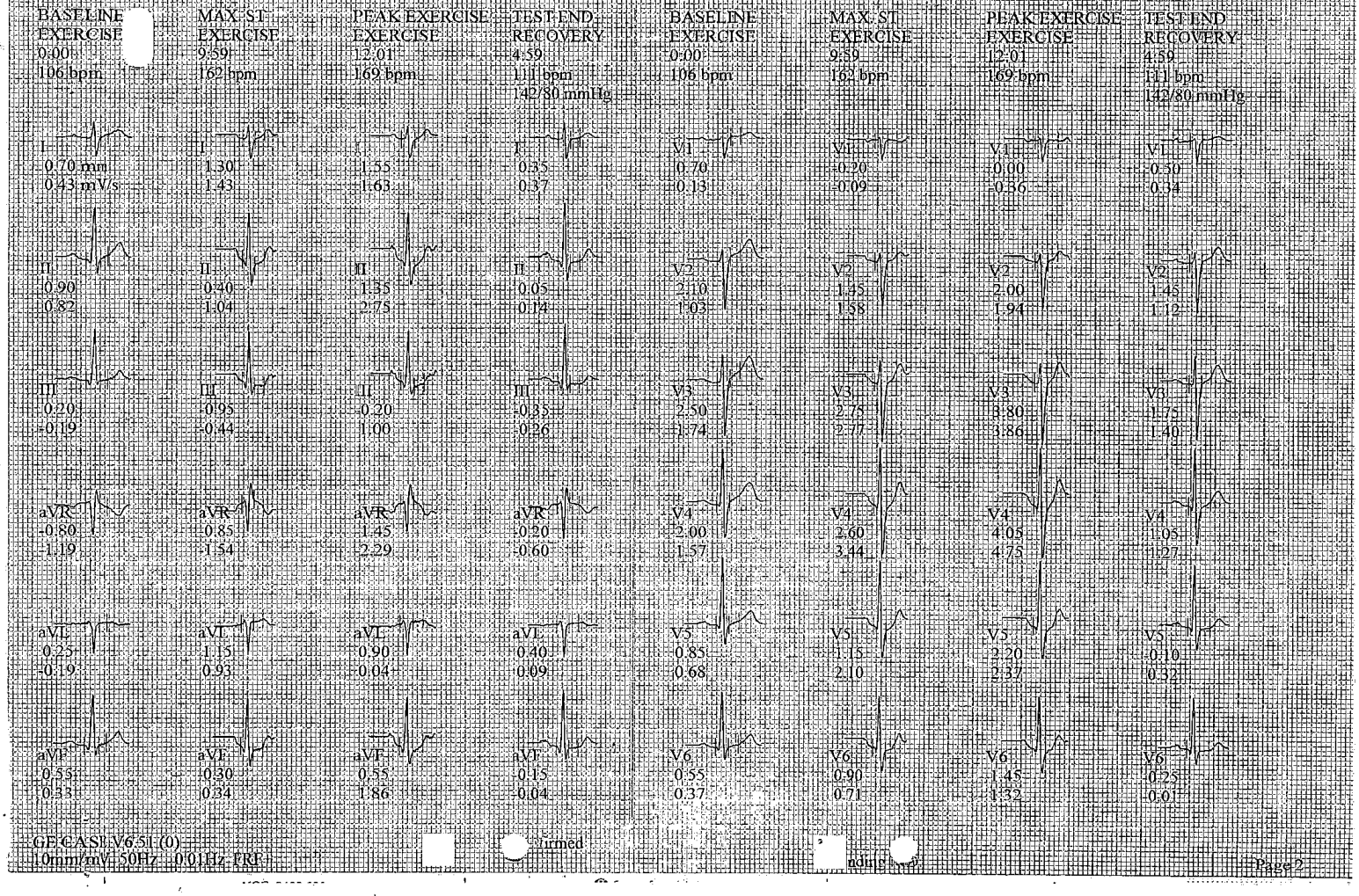

Galloway Stephen
Patient ID 1406650854
22/01/2015
10:57:35
125 bpm
02:30 142/80 mmHg
RECOVERY
#1
02:50
BRUCE
0.0 mph
0.0 %
Grosshouse Hospital
Measured at 80ms Post J (10mm/mV)
Auto Pt(mts
Lead ST(mm) Lead ST(mm)
I 0.75 V1 0.40
II 0.50 V2 1.90
III -0.25 V3 2.60
aVR -0.65 V4 2.10
aVL 0.50 V5 0.45
aVF 0.10 V6 0.20
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II
GE
CASE V6.51
25mm/s 10mm/mV 50Hz 0.01Hz F
IR(V5,V4)1
Start of Test: 10:41:57


Galloway,Stephen
Patient ID: 1406650854
22-01-2015
10:58:35
117 bpm
02:30 142/80 mmHg
RECOVERY
#1
03:50
BRUCE
0.0 mph
0.0%
Crosshouse Hospital
Measured at 80ms Post J (10mm/mV)
Auto Points
Lead ST(mm) Lead ST(mm)
I -0.40 V1 0.50
II -0.05 V2 1.60
III -0.35 V3 1.95
aVR -0.15 V4 1.20
aVL -0.40 V5 0.15
aVF -0.20 V6 -0.30
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II
GE
CASE V6.5
25 mm/s 10 mm/mV 50Hz 0.01Hz
R(V5,V4)
Start of Test: 10:41:57


Galloway Stephen
Patient ID: I406650854
22.01.2015
10:59:35
116 bpm
02:30 142/80 mmHg
RECOVERY
BRUCE
0.0 mph
0.0 %
Crosshouse Hospital
Measured at 80ms Post J (10mm/mV)
Auto-Points
Lead ST(mm) Lead ST(mm)
I 0.35 V1 0.45
II 0.05 V2 1.45
III -0.35 V3 1.70
aVR -0.20 V4 1.00
aVL 0.35 V5 0.10
aVF -0.15 V6 0.20
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
GE
CASE V6.51
25 mm/s 10 mm/mV 50Hz 0.01Hz FR
IR(V5,V4)
Start of Test: 10:41:57

Galloway, Stephen
Patient ID 1406650854
22.01.2015
10:41:57

Crosshouse Hospital



GE CASE V6.51 (0)
10mm/mV 50Hz 0.01Hz FRF

CROSSHOUSE HOSPITAL
NHS AYRSHIRE AND ARRAN
FOR EXERCISE TOLERANCE TEST

CHI: 1406650854
Galloway, Stephen
~~65 Garnock Street~~
Dalry
~~KA24 4AW~~
14/06/1965
Dr ML Perman
MRN: XHI468158

I ..... of .....

hereby consent to undergo the above test, the nature of which has been explained to me by

..... L Porter .....

Date ..... 22/1/15 ..... Signed ..... (Patient)

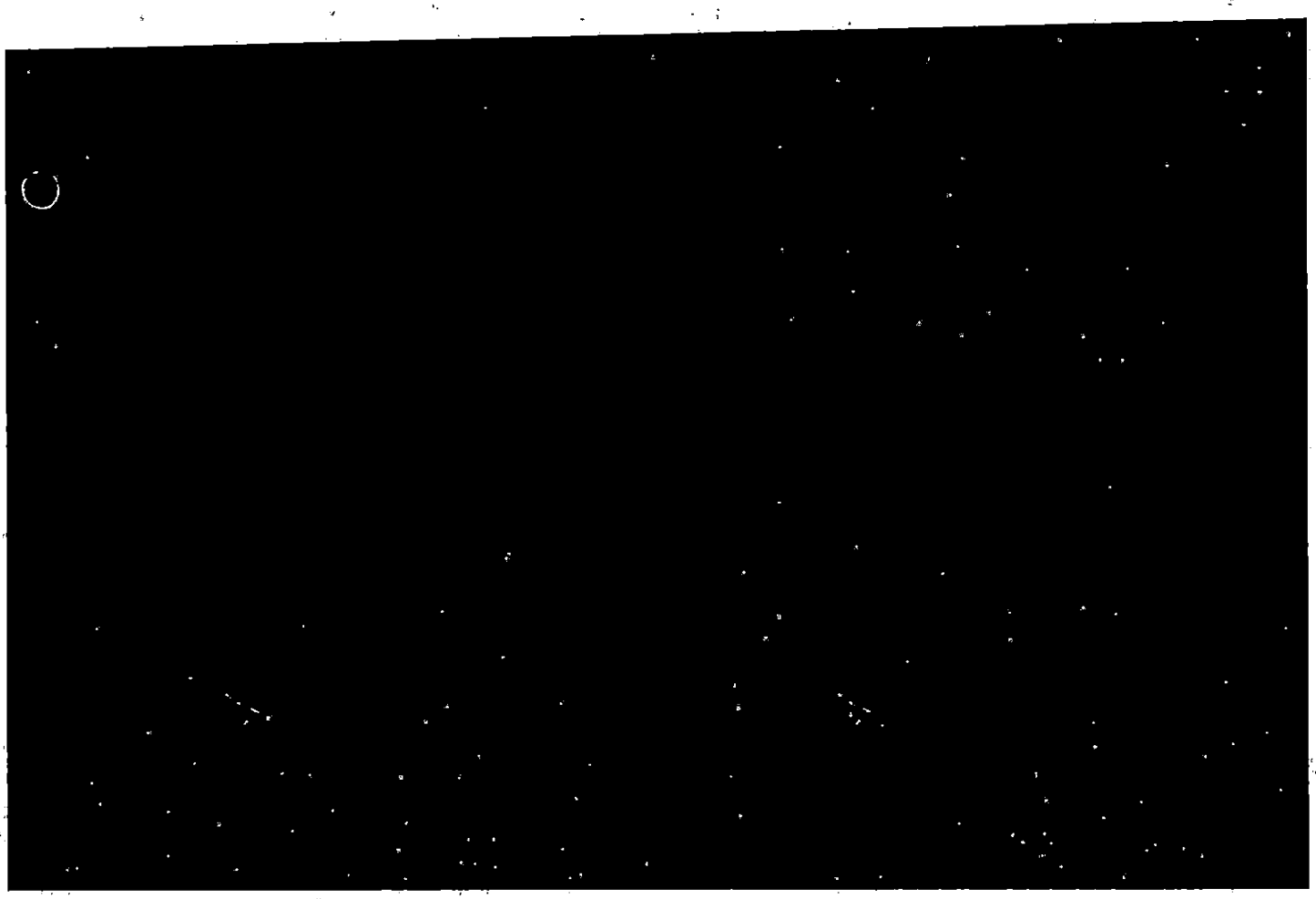
I confirm that I have explained the nature and purpose of this examination to the patient.

Date ..... 22/1/15 ..... Signed .....

PATIENT WEARING SUITABLE FOOTWEAR? **YES** **NO**

(IF NOT – PATIENT TO SIGN DISCLAIMER)

I.....am willing to go ahead with this test despite not having appropriate footwear



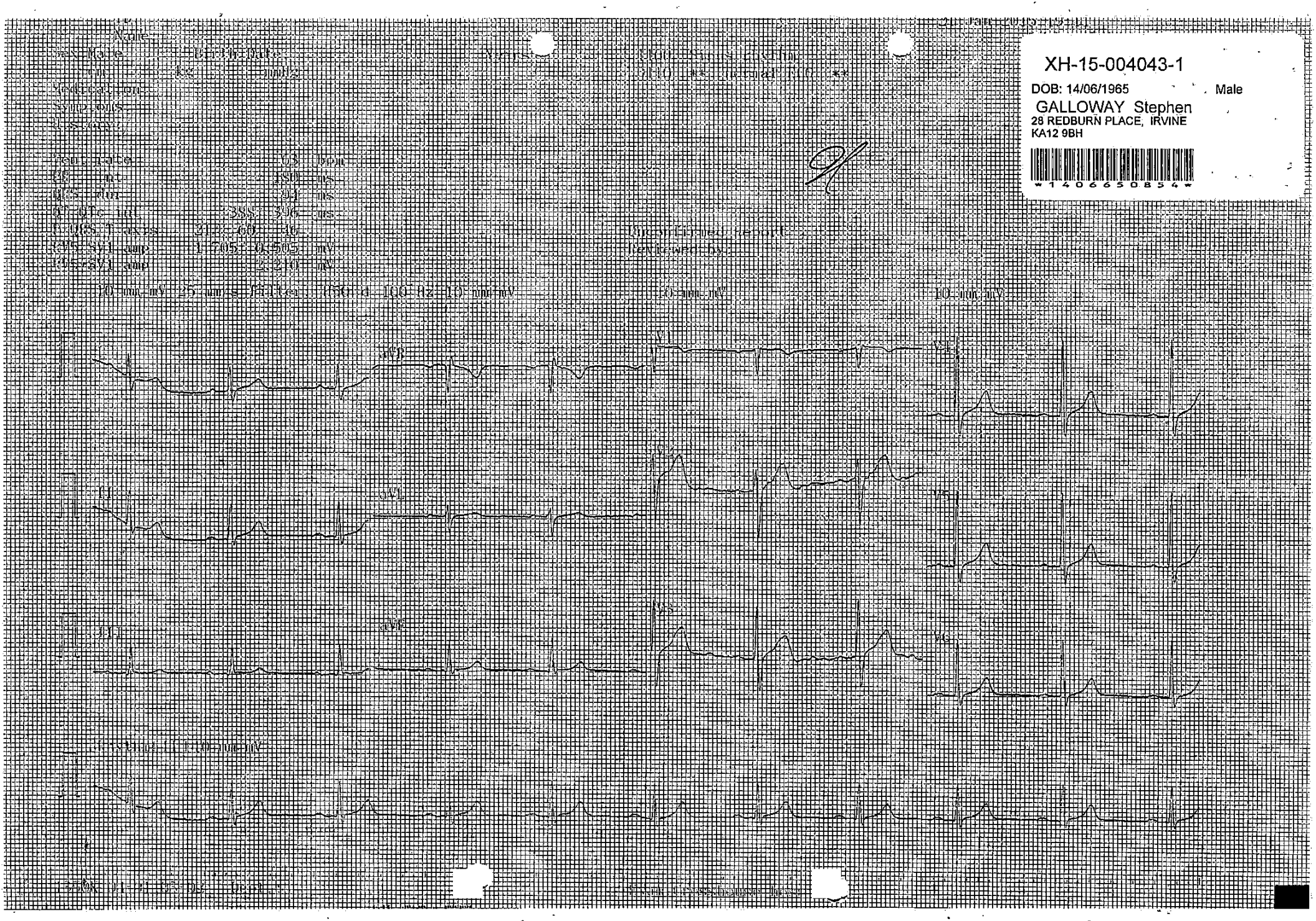
XH-15-004043-1

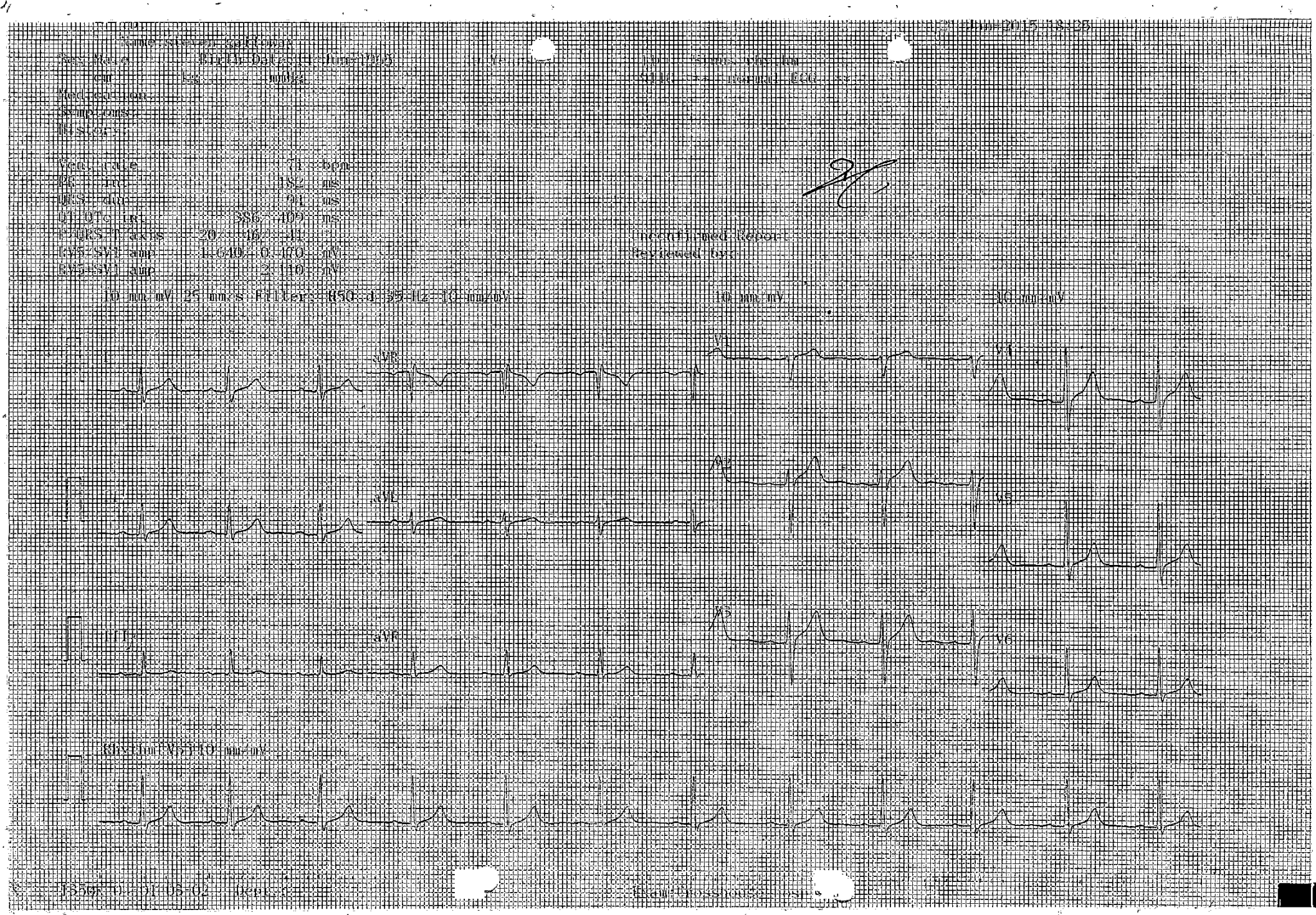
DOB: 14/06/1965 Male

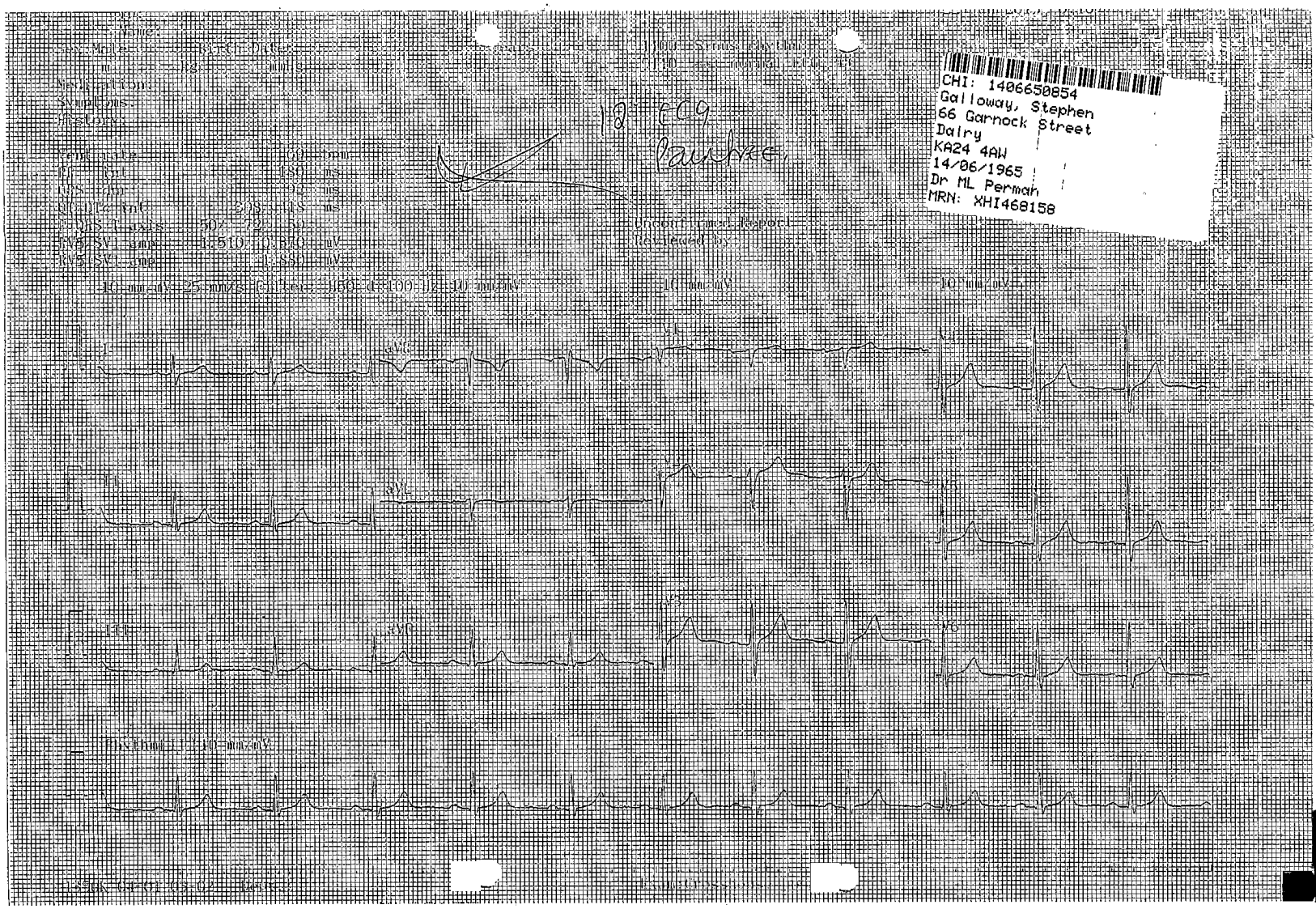
GALLOWAY Stephen

28 REDBURN PLACE, IRVINE

KA12 9BH




Unconfirmed Report
Reviewed by:
10 mm/mV 25 mm/s Filter: H50 L 35 Hz 10 mm/mV
10 mm/mV
10 mm/mV
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
60Hz Filter V1 10 mm/mV


19 ecg
lawhee,
CHI: 1406650854
Galloway, Stephen
66 Garnock Street
Dalry
KA24 4AW
14/06/1965
Dr ML Permah
MRN: XHI468158

11-Oct-1999 01:56:29 STEVEN GALLOWAY CROSSHOUSE HOSPITAL

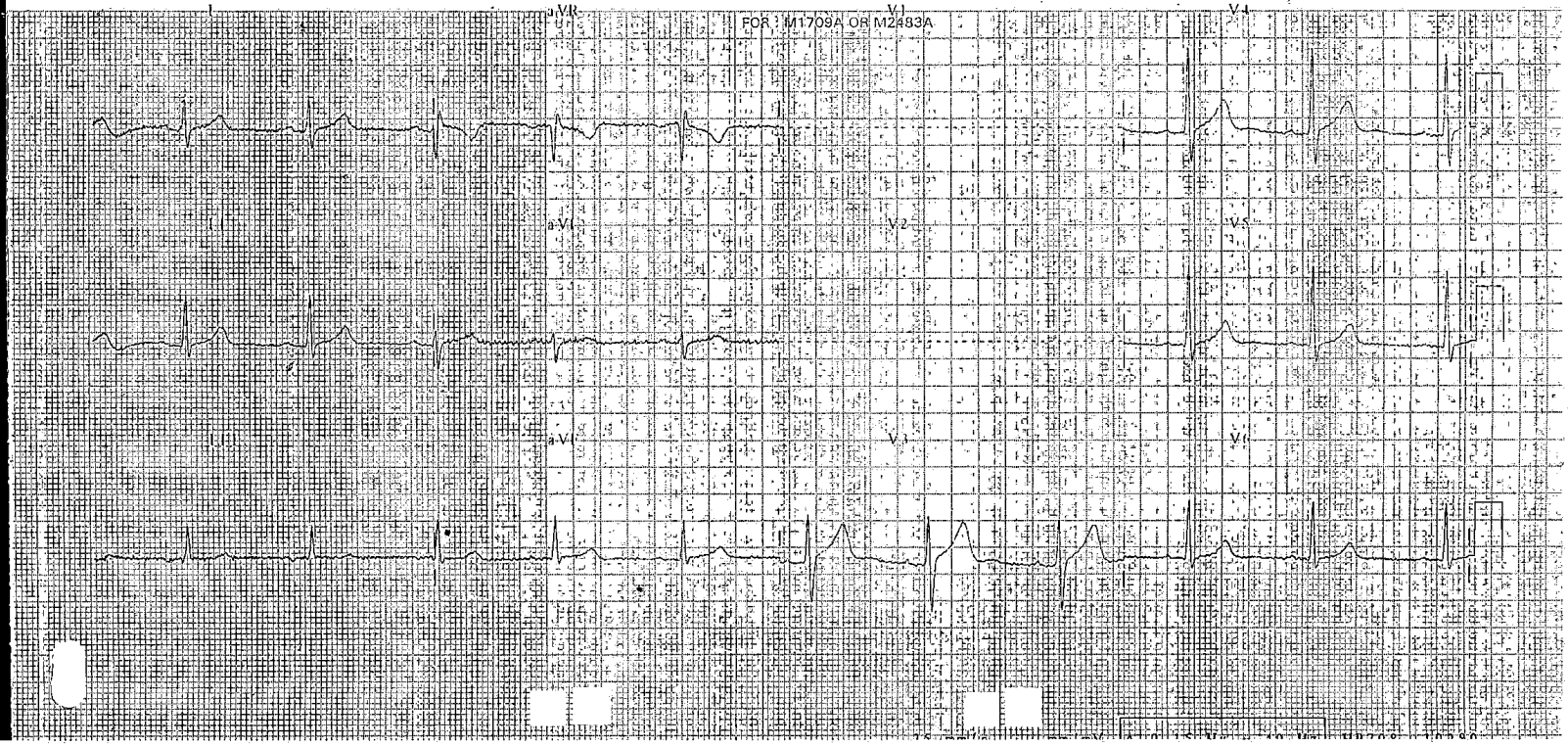
V1 V2

Rate	65	* Incomplete analysis due to missing data in precordial leads
PP	873	. Normal sinus rhythm, rate 65.....Normal P axis, PR, rate & rhythm
QRSD	86	. Nonspecific Anterior ST elevation.....ST > .25 mV V2-V4
QT	372	* Lead(s) V1,V2 were not used for morphology analysis
QTc	387	* Missing lead(s): V1,V2

--Axis--

P	21
QRS	78
T	44

- BORDERLINE ECG - Unconfirmed diagnosis.



11-Oct-1999 01:58:01

Steven GALLOWAY

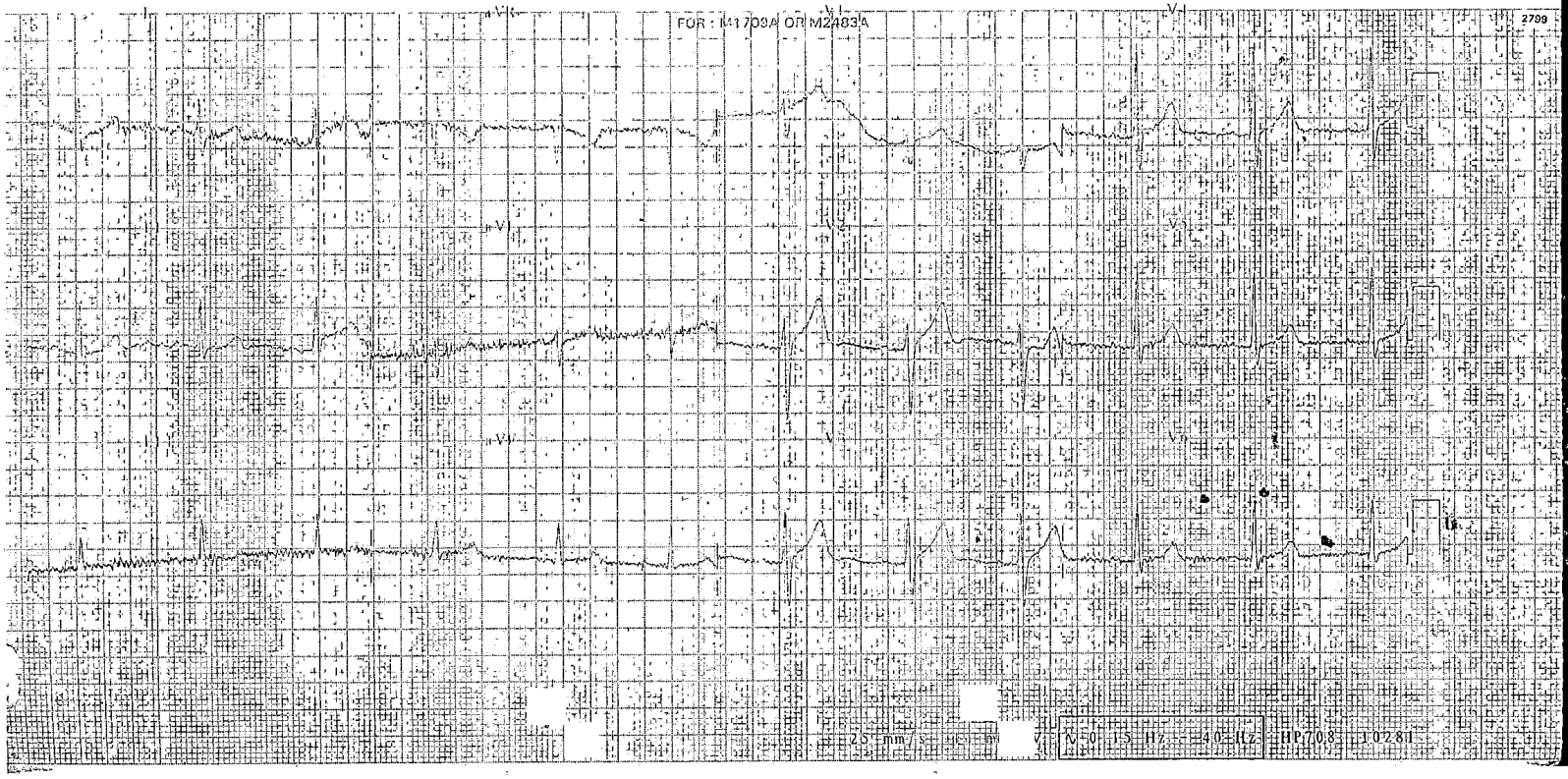
CROSSHOUSE HOSPITAL

Rate	69	. Normal sinus rhythm, rate 69. . . . . .Normal P axis, PR, rate & rhythm
PR	175	. Nonspecific Anterior ST elevation. . . . . .ST .25 mV V2-V4
QRSD	105	
QT	386	
QTc	413	

- Axes -	
P	2
QRS	75
T	18

- BORDERLINE ECG -

Unconfirmed diagnosis.

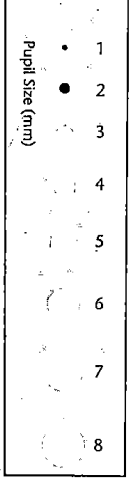


Glasgow Coma Scale

Date:		11/1																											
Time:		11.00																											
Eyes Open	Spontaneous	4																											
	To speech	3																											
	To pain	2																											
	None	1																											
Best Verbal Response	Orientated	5																											
	Confused	4																											
	Inapp. words	3																											
	Incomp. sounds	2																											
	None	1																											
Best motor response	Obeys commands	6																											
	Localise pain	5																											
	Withdrawal to pain	4																											
	Abnorm. flexion to pain	3																											
	Extension to pain	2																											
	None	1																											
GCS TOTAL																													
PUPILS	R Size																												
	R Reaction																												
	L Size																												
	L Reaction																												
LIMB MOVEMENT ARMS	Normal power																												
	Mild weakness																												
	Severe weakness																												
	Abnormal flexion																												
	Extension																												
	No response																												
LEGS	Normal power																												
	Mild weakness																												
	Severe weakness																												
	Extension																												
	No response																												
Initials		AB																											

Pupil Reaction and size

s = sluggish
+ = reaction
- = no reaction



I	Identify self/area/patient.
Si	Situation - what is your concern?
B	Background - relevant Hx/reason for admission.
A	Assessment - A-E findings/NEWS2 score.
R	Recommendation - what do you need & when.

NEWS > 5 THINK SEPSIS Apply SEPSIS 6 within 1 hour

1. Give oxygen to target saturation >94% (COPD 88-92%)
2. IV fluids up to 20ml/kg.
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output and fluid balance chart

NHS Ayrshire & Arran NEWS – National Early Warning Score

NHS Ayrshire & Arran

1406650854

GALLOWAY Stephen

28 REDBURN PLACE, IRVINE
KA12 9BH

DOB: 14/06/1965

XH-24-028073-1

	Ward	Date	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

	Resp rate	BP	HR
Acceptable parameter's			
Dr/ANP initials			
Date			
Dr/ANP discontinue date/sign			

Sp02 Scale 2 Target 88-92%
Signature:
Print Name:
Dr/ANP initials ONLY:
Date:

Patient on home oxygen Y☐ N☐
If yes, add details of oxygen therapy

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
Min 12 Hourly Observations	Min 4 Hourly Observation	Min Hourly Observations	Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	Think Sepsis if Suspicion of Infection	Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS2

Following MDT discussion, it has been agreed that this patient no longer has a requirement for NEWS2

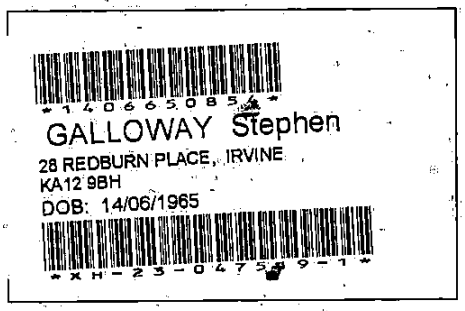
Responsible Clinician: Print Name .....

Designation:.....

Date: ..... Time: .....

NEWS2

NHS
Ayrshire & Arran



PATIENT PROFILE

Please complete below when patient is admitted or transferred to your clinical area

	Admission		Transfer 1		Transfer 2		Transfer 3	
Hospital	XH							
Ward	CAU							
Consultant	CARROLL							
Date / Time	14/10/23 1340							
Relative Informed	(Yes)	No	Yes	No	Yes	No	Yes	No
ID Band in situ	(Yes)	No	Yes	No	Yes	No	Yes	No
CRA Completed *	Yes	No	Yes	No	Yes	No	Yes	No
Completed By - Signature	RP							

The Patient Profile can be used for patients with ongoing regular treatment i.e. for a course of therapy or weekly blood transfusion, however if there is a gap of more than 6 weeks since last attendance update lifestyle assessment (P6)

*If the patient is readmitted or transferred between hospitals an additional MRSA/CRA (P 1 1 must be completed. Additional forms can be obtained from the infection control AthenA site.

This profile can also be used for readmission within 3 days. Please remember to review earlier risk assessments.

Patient's Property – Where possible send belongings home with family

You are asked to keep belongings/valuables to a minimum whilst in hospital. You are responsible for property belonging to you not handed over for safe custody. This includes cash, spectacles, hearing aids, dentures and other personal items and valuables. Valuables should be sent home at first opportunity or given to the nurse if this is not possible.

Signature of Patient / Significant Other:..... Date:.....

Property handed over for Safe Keeping: Yes ☐ No ☐

Date taken to Cashier: ..... Cash & Valuables Ref No:.....

Property handed over for safe keeping

PLACE VALUABLES STICKER HERE

Date Returned:

Clinical Team Signatures

All staff completing this documentation MUST complete this section

Name (Block Caps)	Profession	Ward/ Page No	Signature	Initials
REBECCA PATRICK	SN	CAU	Rebecca	RP
NAOMI NELSON	SN	3D	N. Nelson	NN
Sandi Kelly	DCN	3D	SKelly	SK

Colour Codes for sections within			
	Personal Details		Care Plans
	Lifestyle Assessment		MDT Discharge Plan
	Risk Assessment		Ward Care Notes

Record keeping is an integral part of nursing and midwifery practice. It is a tool of professional practice and one that should help the care process. It is not separate from the process and it is not an optional extra to be fitted in if circumstances allow. Good record keeping is an integral part of nursing and midwifery practice. You need to assume that any entries you make in a patient or client record will be scrutinized at some point.

Personal Details

Prefers to be known as:	Age: 58
Receiving Consultant:	Allocated Consultant:
From where: HOME	Accompanied by: ALONE
Emergency ☑ Elective ☐	Patient Contact Number:
Occupation:	

Reason for Admission

INTOXICATED ? OP

Patient and/or Carers Accounts

Next of Kin/First/Contact/Significant other		Second contact/significant other	
Name: ALLY JOHNSTON		Name: SOPHIE GALLOWAY	
Address:		Address: SAP	
Relationship to patient:	BROTHER	Relationship to patient:	DAUGHTER
Contact No(s) Home:		Contact No(s) Home:	
Mobile:		Mobile:	
Aware of Admission	Yes ☐ No ☐	Aware of Admission	Yes ☐ No ☐
Contact Overnight	Yes ☐ No ☐	Contact Overnight	Yes ☐ No ☐

Patient gives consent to share information with whom?

Spiritual or religious needs

Do you have any spiritual or religious needs whilst in hospital? (please state) Yes ☐ No ☑	Specify needs or cultural practices that place limitations on the patients care (please state)
Do you wish your details to be passed to the hospital chaplaincy service? Yes ☐ No ☑	

Home Circumstances on admission

Do you live alone?	Yes ☐ No ☑	**Living arrangements**	
With dependent partner?	Yes ☐ No ☑	Type of house	
With independent partner/family?	Yes ☑ No ☐	Sheltered Housing	Yes ☐ No ☐
Do you have a carer?	Yes ☐ No ☑	How many steps at entrance?	
Family ☐ Private ☐ Local Authority ☐		How many stairs inside?	
Does carer require additional support? (Consider referral to social work)	Yes ☐ No ☑	Toilet	Upstairs ☐ Downstairs ☐
		Bedrooms	Upstairs ☐ Downstairs ☐
		Bannister	Yes ☐ No ☐

Personal Details

Are you a carer? Yes ☑ No ☐ Please specify Children ☑ Elderly relative ☐ Other ☐							
Who is caring for them currently?							
Family	☐	Social Worker	☐	Neighbour	☐	Nursing Home	☐
Respite Centre	☐	Other ☐					

Community Services in use:		Frequency	Informed of Admission	Informed by/Comments
Home Care provided	Yes ☐ No ☑		Yes ☐ No ☐	
Community Alarm	Yes ☐ No ☑		Yes ☐ No ☐	
Day Hospital	Yes ☐ No ☑		Yes ☐ No ☐	
Community Nurse	Yes ☐ No ☑		Yes ☐ No ☐	
Community Mental Health Nurse	Yes ☐ No ☑		Yes ☐ No ☐	
Learning Disability Nurse	Yes ☐ No ☑		Yes ☐ No ☐	
Visited by Specialist Nurse	Yes ☐ No ☑		Yes ☐ No ☐	Please specify
Does the patient have an ACP?	Yes ☐ No ☑	Ensure it is visible in notes		

Previous Medical History

Details	Dates
COPD	
ALCOHOL xS	

Medications

Is the patient prescribed regular medications?	Yes ☐ No ☑		Have they brought them in?	Yes ☐ No ☐	
Retained in the ward?	Yes ☐ No ☐		Given to relatives?	Yes ☐ No ☐	
Is patient on any high risk medications? Please tick the box below					
Epilepsy	Asthma	Insulin	Anticoagulation	Controlled drugs	Any others note below

Pre-Admission Status Independent ☑ Prompting required ☐ Assistance required ☐

Drug Allergies	**Other Allergies/including food** None Known ☐
NKDA	

Informed Consent and Capacity

While undertaking the patient's clinical assessment, if you have any concerns regarding the patient's capacity and ability to make healthcare decisions refer to medical staff for **assessment and treatment plan** under the Adults With Incapacity (Scotland) Act 2000 and document your actions within the nursing notes. Refer to the Consent policy for further guidance.

Relatives and carers cannot make decisions for patients except in certain circumstances where they hold Welfare Guardianship or Power of Attorney extending to health care decisions under the Adults With Incapacity (Scotland) Act 2000.

Advanced Statement	Yes ☐ No ☐	Guardianship details	Yes ☐ No ☐	Please note name
Power of Attorney details	Yes ☐ No ☐	Financial ☐ Please note name	Welfare ☐ Please note name	
"Getting to know me" in use	Yes ☐ No ☐	If yes to any of the above obtain a copy of the relevant document		

Adult Support and Protection – 3 point criteria — Please see ASP toolkit

If you have a concern about an adult who you believe is or may be at risk of harm complete an ASP/Concern referral. **ASP / Concern referral submitted Yes ☐ No ☐ Date** _____

Referral information can be found on ward ASP folder or AthenA Adult Support and Protection site

4AT		Circle score		
To be completed on all patients over 65 or if appropriate or if the patient has suspected delirium Ask the patient the following questions: (4AT)		1st Assess Date	2nd Assess Date	3rd Assess Date
Alertness	Normal (fully alert, but not agitated, throughout assessment)	0	0	0
	Mild Sleepiness for< 10 seconds after waking then normal	0	0	0
	Clearly abnormal	4	4	4
AMT4	Age, Date of Birth, place (name of the hospital or building) , current year			
	No mistake	0	0	0
	1 mistake	1	1	1
	2 mistakes or untestable	2	2	2
Attention	Instruct patient to list months in reverse order starting at December			
	Lists 7> correctly	0	0	0
	Starts but lists <7 or refuses to start	1	1	1
	Untestable (cannot start became unwell, drowsy or inattentive)	2	2	2
cute Change r fluctuating course	evidence of significant change or fluctuation in mental status within the last 2 weeks and still persisting in the last 24 hours			
	No	0	0	0
	Yes	4	4	4
	Total			
	Sign			

If 4AT > 4 commence TIME bundle. **Please reassess if there is a change in clinical condition.**

If no 4AT carried out please state reason here.....

Driving Status	Do you Drive? Yes ☐ No ☑	
Alcohol Use	Units per week YESTERDAY	
	Suitable for alcohol brief intervention?	Yes ☐ No ☐ NA ☐
	Currently in Treatment	Yes ☐ No ☐ NA ☐
	Refer to alcohol liaison team?	Yes ☐ No ☐ NA ☐
Substance misuse	Substance misuse issues? If yes, give details:	Yes ☐ No ☐ NA ☐
	Currently in treatment	Yes ☐ No ☐ NA ☐
	Refer to substance misuse	Yes ☐ No ☐ NA ☐

Personal Details

Lifestyle Assessments

Communicating : **Interpreter required** Yes ☐ No ☑

Any specific needs	What's your normal?	How is it now?	Comments
Speaking	NO ISSUES		
Reading	NO ISSUES		
Writing	NO ISSUES		
Vision (please specify if glasses/contact lenses are worn)	NO ISSUES		
Hearing (please specify if hearing aids are worn and if in patient possession)	NO ISSUES		

Breathing	What's your normal?	How is it now?	
Do you normally have any issues breathing?	NO ISSUES		Do you suspect the pati has a respiratory infection? Isolate with appropriate precautions and refer to IPC site on Athena

Equipment / aids - tick all that apply:
Inhalers ☐ oxygen-concentrator ☐ cylinder ☐ nebulisers ☐ tracheostomy ☐

Do you smoke? Yes ☐ No ☐ If so how many? .....

Patient wishes nicotine replacement therapy? Yes ☐ No ☐

Refer All smokers to **"Quit your way"** for discussion about smoking management whilst in hospital (Ask patients permission) Date referred..... sign.....

Mobility	What is your normal?	How is it now?	Comments
Bed Transfers	IND		
Chair Transfers	IND		
Balance	IND		
Walking Any issues with foot health affecting mobility	IND		

Oral Care

If the answer to any of the questions below is **'yes'**, please complete an Oral Hygiene Care Plan

Does the patient need assistance carrying out their basic oral care?	Yes ☐ No ☑
Does the patient need assistance in caring for their denture?	Yes ☐ No ☑
Is the patient suffering from mouth pain?	Yes ☐ No ☐

Comments

Lifestyle Assessments continued

Eating and Drinking		If yes what support is required?
Support required for eating/drinking	Yes ☑ No ☐	
Equipment required to support eating/drinking **Please state what equipment required**	Yes ☐ No ☑	
Is Patient on nutritional supplements / enteral feed at home Yes ☐ No ☑		Type:
Likes..... Dislikes.....		Modified fluid consistency Level N/A
		Modified diet consistency Level N/A
Swallowing ability impaired Yes* ☐ No ☑ *If Yes, date referred to SLT: Name of referrer: Signature of referrer:		Consent to therapeutic diet (Cultural, ethnic, religious requirements) Yes ☐ No ☑
		Therapeutic diet details:

Eliminating	What is your normal	How is it now?	Do you suspect the patient has infective diarrhoea? Send a sample and isolate patient.
Normal bowel habit. **When did your bowels last move?**	CONTINENT		
Any problems passing urine?	CONTINENT		

Does the patient have a urinary catheter in situ Yes ☐ No ☑ Date of catheter insertion.....

Long term catheter Yes ☐ No ☑ | Date due changed

If yes, apply the Catheter Care Bundle

Complete continence assessment if required ☐
Refer to Adult Continence Assessment Pathway algorithm

Urinalysis Results. Please circle where appropriate

NAD ☐	Protein Trace + ++ +++ ++++	Blood Trace + ++ +++	Glucose Trace + ++ +++ ++++	Leucocytes + ++ +++	Nitrates -ve +ve

Only send for culture if suspected;

UTI ☐ Sepsis ☐ **MSSU Sent ☐** **CSU Sent ☐**

Date Last Menstrual Period (if appropriate) Pregnancy Test (if appropriate) +ve ☐ - ve ☐

Glucometer reading result

Personal Cleansing and Dressing	What is your normal	How is it now?	Comments
What type of assistance is required by the patient? **(please consider patient preferences)**	IND		

Person Centred Care:

To promote person-centred care our focus is changing from asking 'What's the matter with you "' to asking "What matters to you'.

We can do this by reliably covering the five 'Must do with me' elements of care with patients and/or their families and carers. This will help to ensure all of the interactions between people using our services and the staff delivering them is person-centred and are characterised by listening, dignity, compassion and respect.

The information required for the following 5 Must Do questions can be captured during your conversations with the patient and their families. There may be no need for you to ask these questions directly but gather that information during the admission process and record below

'MUST DO WITH ME'
❶ **What matters to you?** *Your personal goals and the things that are important to you have been discussed and form the basis of your care or treatment.*
❷ **Who matters to you?** *We have asked you about the people that matter most in your life and we have given you the opportunity to involve them in the way that you choose*
❸ **What information do you need?** *We have provided you with understandable full information and supported you to make decisions that take account of your personal goals and the things that are important to you.*
❹ **Nothing about me without me.** *You will always be given the opportunity to be involved in discussions. All information exchanges and communication between professionals or between different services or supports are transparent and always provide you with the opportunity either to be present or to contribute to the process.*
❺ **Personalised contact**

Multi – Disciplinary Discharge Plan

Aim: To ensure a safe and timely discharge planned in partnership with the local authorities, third sector patient/carer and staff to ensure a safe return to community.

Discharge planning should be commenced on day of admission. Consider early referral to social work.

PATIENTS SHOULD BE CONSIDERED FOR CRITERIA LED DISCHRAGE IF USED APPLY STICKER TO MDT DISCHARGE SUMMARY

Estimated date of discharge..... **Actual date of discharge**.....

Date	Is the discharge location different from the admission location /Home/ family /care home/ nursing home/,community	Yes	No	Initials
	EDD set and patient and family/carers aware			
	Does the patient require a discharge planning meeting? If yes record date and outcome overleaf.			
	Does the patient require homecare? If yes, please record date and time below.			
	Homecare confirmed to start on:.....(date) at..... (time)			
	House keys available? ..... Key safe number			
	Own transport arrangements			
	Hospital booked transport Ambulance am pm Ref No: Mode: Carry chair required ☐ chair 2 man ☐ Stair climber ☐ Stretcher ☐ Any access issues.....			
	Referral through PMS Package requested: New homecare ☐ Restart existing package ☐ Increase package ☐ Handlers single ☐ double ☐ Rehab – 1. General Rehab – complete referral to appropriate service via track care 2. Stroke rehab – complete referral to appropriate service via track care 3. Neuro rehab – complete form on Athena			
	IDL complete			

	Equipment	**Date for delivery**	**Delivery confirmed**

Day of Discharge checklist	Yes	No	NA	Initials
Cannula removed				
Discharge Drugs Available Alert: If patient is diabetic, complete the diabetes discharge checklist				
Patients own meds returned				
Discharge prescription given & explained to patient & family If no, please add to discharge summary				
If DNACPR keep copy in patients notes and send original home. Give to ambulance crew if applicable				
If patient has an ACP send it home with patient.				
Inform family/NOK when patient leaves the ward (including transfer to discharge lounge)				
Oral supplements/enteral feeding equipment?				

Multi – Disciplinary Discharge Plan (Continued)

Referrals for support when patient goes home			
	Date of referral	Initials	Comments
Intermediate Care Team			
Dietician			
SLT			
Physio			
OT			
Community Nurse			
Podiatry			
Other			

Please share discharge plan on transfer

Signature of transferring nurse.....

Signature of receiving nurse.....

Date.....

Please use the following section to record all further discharge planning information.

Date	Time	All Care and communication relating to Discharge	Initials

Infection Prevention and Control Clinical Risk Assessment (CRA): Multi-Drug Resistant Organism (MDRO Admission Screening)

Hospital + Ward/Dept: XH CAU
Admission date: 14/10/23 Time: _____

CPE Clinical Risk Assessment (on admission)

Date of Screen: 14/10 Time: _____ Print Name: _____ (Staff Member)

(Y/N)

1. **Patient has history of CPE colonisation or infection at any time in the past** (confirm by checking PMS for ALERTS and confirm by asking the patient if there is no record on system) ☑

2. **In the past 12 months** (this will most often require asking the patient):
   - **Patient has been an inpatient outside Scotland** ☑
   - **Patient has received holiday dialysis outside Scotland** ☑
   - **Patient has been close contact of someone with CPE** ☑

If YES, patient should be managed as a CPE positive case – must be placed in a single room and the case discussed with IPCT

If YES, to any, patient is at increased risk of CPE colonisation, must be placed in a single room and the case discussed with IPCT

Discussed with patient and provided information leaflet ☐

1. PATIENT PLACEMENT (Single Room)

Date _____ Signature _____

AND

2. SAMPLES FOR TESTING (refer to CPE policy)
Rectal swab (or stool sample) ☐
AND
Wound swab, if present ☐
AND
Invasive device site swab, if present (exc urinary catheter site) ☐
AND
CSU if catheterised ☐

Date _____ Signature _____

MRSA Clinical Risk Assessment

Date of Screen: _____ Time: _____ Signature: _____

(Y/N)

1. **Patient has history of MRSA colonisation or infection at any time in the past** (confirm by checking PMS for ALERTS and confirm by asking the patient if there is no record on the system) ☐
2. **Patient admitted from somewhere other than home e.g. another hospital, care home** (confirm by checking admission documentation / PMS) ☐
3. **Patient has wound / ulcer or invasive device present before admission** (may require physical inspection) ☐

If **YES**, to any, patient is at increased risk of MRSA colonisation

If **NO** to all **AND** patient is in high-impact speciality*

Discussed with patient and provided them with leaflet ☐

1. PATIENT PLACEMENT (refer to MRSA Policy)

Single Room ☐

If placement not possible as per policy, undertake risk assessment and document reasons below:

_____

_____

2. SAMPLES FOR TESTING
Nasal + perineal ☐
AND
Wound/skin break swab, if Present ☐
AND
Invasive device site swab, if present (exc urinary catheter site) ☐
AND
CSU if catheterised ☐

Date _____ Signature _____

**High impact specialties refers to:*
Intensive care, Orthopaedics, Renal Medicine, Vascular Surgery
Note: If the patient is transferred to UHC or UHA from any NHS A&A Hospital, an additional CRA must be carried out. Additional forms can be obtained from the IPC AthenA site.

January 2019 Version 0.12

If further advice is required contact the Infection Prevention & Control Team (ext 25765) or the on call Consultant Microbiologist (via switchboard)

Nutritional Screening Malnutrition Universal Screening Tool (MUST)

Food Fluid and Nutrition

Step 1 Measure height and weight to get a BMI score
Step 2 Note percentage unplanned weight loss and score
Step 3 Establish acute disease effect and score
Step 4 Add scored from steps 1, 2 and 3 together to obtain overall risk of malnutrition
Step 5 Commence the care plan appropriate to the risk category

Screening Results

Please indicate if measurements are Measured (M), Reported (R) or Estimated (E)
Please Refer to BMI graph on ward

Date	14/10/23				
Time	1330				
Ward	CAU				
Height in metres (M)or(R)or(E)	5Ft 5 m ( )	m ( )			
Current weight in Kg (M)or(R)or(E)	72 Kg ( )	Kg ( )	Kg ( )	Kg ( )	Kg ( )
BMI	26.4				
Is patient within obese category?					
Usual weight (Kg)	Kg ( )				
Signature	RD				
MUST					
Step 1: BMI Score >20 (>30 = Obese) 0 18.5 - 20 1 < 18.5 2	0				
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months. <5% 0 5 - 10% 1 >10% 2	0				
Step 3: Acute Disease Effect Score If patient is acutely ill **and** there has been or is likely to be no nutritional intake for>5 days Score 2 ..... Not applicable Score 0.....	0				
Step 4: Overall Risk of Malnutrition Total:	0				
Step 5:		1 = Medium Risk			

N.B. When completing step 2, always compare the most recent weight with the usual weight and not the previous week's weight.

PLEASE RECORD REASON FOR WEIGHTS NOT BEING RECORDED

Date	Reason	Initials

Malnutrition Universal Screening Tool

('MUST') Multidisciplinary Care Plan

(FFN)

Patient Problem	
Nutritional screening has identified the patient as being	Low ☐ **Medium** ☐ High ☐ risk of malnutrition
Patient identified as having other nutritional problems	e.g. obesity, chewing certain foods (please specify)

Goal
To meet patients nutritional and fluid requirements

Date	Time	Initial	Planned Nursing Interventions/Support	End Date	Initial
			[redacted]		
			Assistance required (specify) e.g. helping, prompting, cutting up food, opening packets:-		
			Individual / therapeutic dietary requirements (specify) e.g. likes/dislikes religious/ethical/cultural:-		
			Modified eating equipment (specify) e.g. cutlery.		
			Assist patient to select appropriate meals from menu card.		
14/10/23	1330	RP	Ensure fresh drinking water is offered regularly and available at all times, where clinically appropriate.		
			Consider patients positioning and support oral hygiene, if required.		
			Ensure patients nutritional needs recorded on nutrition board.		
			Monitoring and review care plan **repeat screening weekly** (Monthly continuing care).		
			This care plan has been discussed and agreed with the patient as appropriate.		
			Medium Risk Care Plan (complete low risk section also)		
			Commence food chart for a minimum of 3 days. Only discontinue if/when dietary intake is adequate.		
			If intake is insufficient, offer patient milk to drink with / and between meals and suitable additional snacks.		
			Record accurate fluid intake / output on fluid balance chart until established that oral intake is adequate. If intake per 24 hours is inadequate consider IV/SC fluids.		
			Provide "Food First" nutrition information leaflet to patient/carer/relative		
			RED TRAY Yes ☐ No ☐ **RED JUG** Yes ☐ No ☐		
			[redacted]		
			Refer to Dietitian, ensuring the MUST score is included.		
			Discontinue food chart only when advised by Dietitian.		
			Administer and monitor enteral feed via NG/PEG route as per local guidelines.		

Please record any Therapeutic/Special Diet/Fluids/Oral supplements

Diet / supplement	Date commenced	Comments	Date discontinued

If on oral nutritional supplements, please commence on supplement monitoring chart. Ensure dietary needs are reflected on the patient's bed board and ward nutritional information board.

Care Plan

Date	Time	Int/s	Planned Nursing Interventions/Support	End Date	Int/s
			This care plan has been discussed and agreed with the patient as appropriate.		

Daily Preliminary Pressure Ulcer Risk Assessment (PPURA)

(unless full waterlow required)

Points to consider

- Use within 6 hours of admission to care area
- People who are overweight may not be well nourished
- Please sign after each check

Date 14/10/23	**Time** 1415	
Mobility		
Patient is fully mobile without equipment/assistance	Yes ☑ No ☐	
Continence		
Patient is fully continent	Yes ☑ No ☐	**If *No*, to any questions undertake Waterlow Assessment and apply SSKIN bundle as indicated.**
Nutrition		
Patient appears to be well nourished and able to eat and drink	Yes ☑ No ☐	
Skin		**If all answers Yes, complete a daily PPURA below.**
Skin is healthy and intact **Assess condition of skin, any wounds/lesions/stomas**	Yes ☑ No ☐	
PT DECLINED SKIN CHECK		

Use daily if the person is identified to be "not at risk"

Mobility	Person is fully mobile without equipment/assistance
Continence	Person is fully continent
Nutrition	Person appears well nourished and able to eat and drink
Skin	Persons pressure areas are healthy, with no signs of redness, discolouration, including bruising or ulceration

Record your answer in the grid below **Y** – Yes or **N** – No
If the answer is **Yes** to all statements use this chart daily
If the answer is **No** to any questions undertake Waterlow Assessment and apply SSKIN bundle as indicated.

Date	Time	Mobility	Continence	Nutrition	Skin Inspected	Is a full pressure ulcer risk assessment required?	Signature
17/10/23	0200	Y	Y	Y	N	NO	Skelly

Risk Assessment Tools

Adapted Waterlow Pressure Area – Risk Assessment

More than one score can be used in each section. Complete assessment according to PPURA or if there is a change in individuals condition. Reassess score as per protocol.

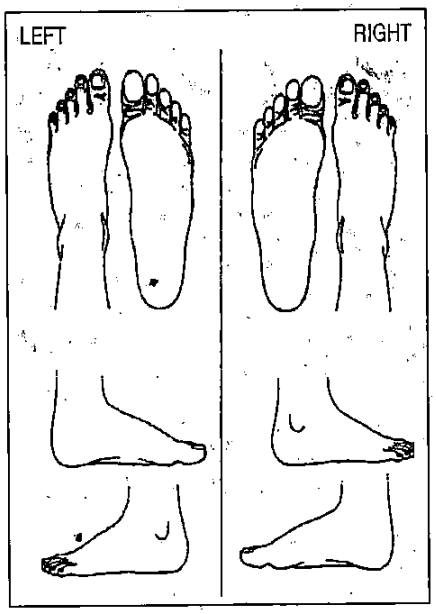
<10 Low Risk - Reassess weekly
15+ High Risk - Reassesson alternate days
10+ At Risk - Reassess twice weekly
20+ Very High Risk - Assess daily

		Date	14/10											
		Time	1415											
Sex														
Male 1	Female 2		1											
Age														
14 - 49		1												
50 - 64		2	2											
65 - 74		3												
75 - 80		4												
81+		5												
Build/Weight for Height (BMI=weight in Kg/height in m²)														
Average - BMI 20-24.9		0	0											
Above average - BMI 25-29.9		1												
Obese - BMI > 30		2												
Below average - BMI < 20		3												
Continence														
Complete/catheterised		0	0											
Urinary Incontinence		1												
Faecal incontinence		2												
Urinary and faecaly incontinent		3												
Skin Type - Visual Risks Area														
Healthy		0	0											
Tissue paper (thin/fragile)		1												
Dry (appears flaky)		1												
Oedamatous (puffy)		1												
Clammy (moist to touch) pyrexia		1												
Discoloured/Bruising/Grade 1		2												
Broken (established ulcer) Grade 2 - 4		3												
Mobility														
Fully mobile		0	0											
Restless/fidgety		1												
Apathetic (sedated/depressed/reluctant to move)		2												
Restricted (restricted by severe pain or disease)		3												
Bedbound (unconscious/unable to change position/traction)		4												
Chair bound (unable to leave chair without assistance)		5												
Nutritional Element														
Unplanned weight loss in past 3-6 months														
< 5% Score **0**, 5-10% Score **1**, >10% Score **2**		0-2	0											
BMI >20 Score **0**, BMI 18.5-20 Score **1**, BMI < 18.5 score**2**		0-2												
Patient/ client acutely ill or no nutritional intake > 5 days		2												
Special Risks - Tissue Malnutrition														
Multiple organ failure/terminal cachexia		8												
Single organ failure e.g. cardiac, renal, respiratory		5	5											
Peripheral vascular disease		5												
Anaemia = Hb < 8		2												
Smoking		1												
Special Risks - Neurological Deficit														
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*		4-6	0											
Special Risks - Surgery/Trauma														
On table > 2 hours (up to 48 hours post op)		5												
On table for up to 6 hours (up to 48 hours post op) provided 5 the rate of recovery is normal)			0											
Orthopedic/below waist/spinal		8												
Special Risks – Medication														
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*			8											
		Total												
		Initials	RP											

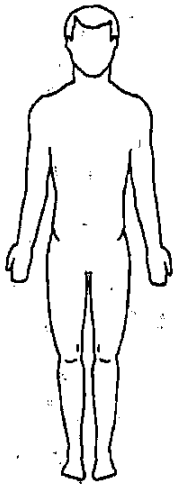
Pressure Ulcer Record

Indicate by circling, numbering and dating all pressure damage on diagrams, then complete box below.

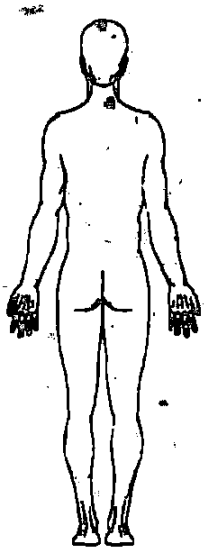
Initiate SSKIN care plan/wound assessment chart



Anterior view



Posterior view



Date	Number of Ulcer	Location of Ulcer	Grade of Ulcer	Datix – Insert reference (grade 2-4 and suspected deep tissue injury	Logged on Safety Cross (Grade 1-4)	Signature	Print Name

Scottish Adapted European Pressure Ulcer Advisory Panel (EDUAP)-Pressure Ulcer Grading Tool 2014

GRADE 1 Intact skin with non blanchable redness, usually over a bony prominence. Darker skin tones may not have visible blanching but the colour may differ from the surrounding skin. The area may be painful, firmer, softer, warmer or cooler than the surrounding tissue.

GRADE 2 Loss of epidermis/dermis presenting as a shallow open ulcer with red/pink wound bed without slough or bruising. May also present as a blister.

GRADE 3 Subcutaneous fat may be visible but bone tendon or muscle is not visible or palpable. Slough may be present but does not obscure the depth of tissue loss. Often includes undermining or tunnelling

GRADE 4 Extensive destruction with exposed or palpable bone, tendon or muscle. Slough may be present but does not obscure the depth of tissue loss. Often includes undermining or tunneling

DEEP TISSUE INJURY – Epidermis is intact but the area appears purple or maroon or is a blood filled blister over a dark wound bed. Over time the skin will degrade and develop into deeper tissue loss.

UNGRADABLE - Full thickness skin loss where the depth of the ulcer is completely obscured by slough/necrosis. Until enough slough or necrotic tissue is removed to expose the base of the wound the true depth cannot be determined. It may be a grade 3 or 4 once debrided

All acquired pressure ulcers graded 2 - 4 and suspected deep tissue damage, must be reported via Datix. Refer to podiatry for at risk feet and foot wounds using "CPR for Feet" Criteria.

Risk Assessment

NHS Ayrshire & Arran

Pressure Prevention Care Plan (PA)

Patient Problem/Need
Patient is **at risk** of developing a pressure ulcer
Patient has a pressure ulcer/s grade .....
Goal
Patient's skin will remain intact
To promote healing of ulcer and prevent infection

Date	Time	Initial	Planned Nursing Interventions	Discontinued Date / Time	Initial
			Calculate and record the Waterlow score on admission and recalculate as the patient's condition changes and on a regular basis.		
			Check feet, **protect** at risk (known PVD, neuropathy/ulcer present) & **refer** to podiatry all patients with foot ulcer.		
			Ensure regular repositioning is carried out and documented on SSKIN bundle.		
			Ensure patient has appropriate equipment in place according to their needs (consider mattress/cushion/heel protectors).		
			The patient should not sit out of bed for longer than 2 hours without being repositioned (for acutely ill patients return to bed for a minimum of 1 hour).		
			Use sliding sheets to prevent shear and friction during movement in bed ensure this is documented on SSKIN bundle (Sliding sheets should not be left under the patient).		
			When the patient is incontinent use a pH balanced cleanser to clean and barrier products to protect as per: Scottish Excoriation & Moisture Related Skin Damage Tool.		
			Encourage a healthy, well balanced diet and adequate fluid intake. Refer to dietician if necessary.		
			Refer to Tissue Viability any complex wounds or if admitted with grade 3 or above pressure ulcers.		
			If the patient has a grade 2 or above pressure ulcer a wound assessment chart is required		
			This care plan has been discussed and agreed with the patient as appropriate. Record evaluations in notes.		

CPR for Feet	
Check	Check both feet: * Are there any breaks in the skin/areas of discolouration? * Are there any ulcers present? * Is neuropathy present? * Is action required?
Protect	Protect feet if: * Pressure damage/ulcer present or at risk due to: * Neuropathy * Previous ulcer/pressure damage or amputation * Bed bound or fragile skin
Refer	Refer all patients with a foot ulcer / pressure damage or other major concern to the Podiatry Department or Tissue Viability Services for treatment and reassessment of pressure relief requirements. Tel ..... Referal Date:..... Signature of Referrer.....

Falls for All Bundle

Falls for All Bundle - 5 Questions	Ward	Ward	Ward	Ward	Ward	Ward
	CAU	3D				
Date	14/10/23	17/10				
Time	1415	0200				
a. Has the patient fallen in the last 6 months – including during this admission?	Y/(N)	(Y)/N	Y/N	Y/N	Y/N	Y/N
b. Does that patient have cognitive impairment or possible delirium?	Y/(N)	Y/(N)	Y/N	Y/N	Y/N	Y/N
c. Does that patient attempt to walk alone although unsteady or unsafe?	Y/(N)	Y/(N)	Y/N	Y/N	Y/N	Y/N
d. Does the patient or their relative/s have fear or anxiety, Re falling?	Y/(N)	Y/(N)	Y/N	Y/N	Y/N	Y/N
e. Based on your clinical judgment, is this patient at high risk of falling?	Y/(N)	Y/(N)	Y/N	Y/N	Y/N	Y/N
Staff initial	RO	SL				

- **If yes to any of the above, the patient is deemed as a vulnerable patient and should be commenced on the falls bundle within the care and comfort rounding chart.**
- **A slips trip and falls care plan should be completed and individualised as appropriate.**
- **Evaluate using (F) within nursing notes**

Falls for All Bundle - 5 Questions	Ward	Ward	Ward	Ward	Ward	Ward
Date						
Time						
a. Has the patient fallen in the last 6 months – including during this admission?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
b. Does that patient have cognitive impairment or possible delirium?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
c. Does that patient attempt to walk alone although unsteady or unsafe?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
d. Does the patient or their relative/s have fear or anxiety, Re falling?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
e. Based on your clinical judgment, is this patient at high risk of falling?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Staff initial						

- **If yes to any of the above, the patient is deemed as a vulnerable patient and should be commenced on the falls bundle within the care and comfort rounding chart.**
- **A slips trip and falls care plan should be completed and individualised as appropriate.**
- **Evaluate using (F) within nursing notes**

Slips, Trips and Falls – Care Plan (F)

(to be used in conjunction with Falls for All bundle)

Patient Problem/Need
Patient is considered to be at risk of falling
Goal
To promote and maintain patient safety and reduce the risk of falls

Date	Time	Initial	Planned Nursing Interventions	Discontinued Date/Time	Initi
			Orientate patient and family/carers to ward environment on admission and each shift.		
			Ensure buzzer within reach.		
			Explain importance about calling for help when needed.		
			Ensure that bedside table and key belongings are within easy reach.		
			Ensure patient wears appropriate clothing and footwear.		
			Ensure that patient is wearing spectacles if appropriate.		
			Discuss with family/carers how to assist with interventions.		
			Ensure that patient/family receives an explanation of risk and the measures in place to minimise this risk and document outcome.		
			Ensure that standard bed frame is used and left in a low position with brakes on.		
			Select a chair that is the appropriate height and design for the patient (seek guidance from Physio and OT).		
			When in use ensure that chair/commode brakes are secure.		
			Ensure that area is illuminated appropriately at night time.		
			Liaise with medical team re: medication review.		
			Consider referral to Physiotherapy, Occupational Therapy, Social Work.		
			Monitor lying and standing blood pressure.		
			Supervise patient when transferring as per moving and handling risk assessment.		
			Supervise patient when mobilising as per moving and handling risk assessment.		

			Offer toileting facilities as appropriate.		
			Ensure that patient is cared for in an area proximal to toilet facilities, if possible.		
			Encourage family, if present, to sit with patient (as appropriate).		
			Encourage family/carers to report to nursing station when ending their visit.		
			Consider appropriate equipment in liaison with Physio and / or OT.		
			Ensure yellow sticker is inserted into patient's notes after each fall.		
			Patients who may be confused or have had repeated falls where possible should be cared for in an area within the ward that is within easy view of nursing staff.		
			Consider a higher level of supervision of the patient.		
			Consider the use of a low level variable height bed.		
			Above care plan has been discussed and agreed with the patient and / or family / carer		

NHS Ayrshire and Arran

Bedrails Risk Assessment

Date of Admission .....

- Each statement must be answered - Circle answer
- Complete Risk Assessment in conjunction with Bedrails Algorithm.
- Refer to Guideline – G115 -Safe use of Bed Rails – Adult in-patient settings Guideline
- As accountable RN ensure you have undertaken a visual check of the bedrail prior to use and are satisfi that there are no obvious faults.

Re Assessment Occurs

- Weekly
- When the patient's condition changes (i.e. patient falls / post surgery / change in medication / cognitive state changes)

Ensure clear identification of a change in use of bedrails within documentation and at be space if consent obtained from patient

Risk Factors	Ward: CAU Date: 14/10 Time: 1445	Ward: 3D Date: 17/10 Time: 0200	Ward: Date: Time:	Ward: Date: Time:
1. Is the patient at risk of **falling** from bed?	Yes / (No)	Yes / (No)	Yes / No	Yes / No
2. Is the patient at risk of **intentionally**	Yes / (No)	Yes / (No)	Yes / No	Yes / No
3. Is the patient at risk of **unintentionally**	Yes / (No)	(Yes) / No	Yes / No	Yes / No
4. Does the patient **understand** the purpose of the bedrails? Consider communication difficulties and physical / Cognitive condition.	(Yes) / No / NA	(Yes) / No / NA	Yes / No / NA	Yes / No / NA
5. Does the patient **consent** to the use of bedrails?	Yes / (No) / NA	Yes / (No) / NA	Yes / No / NA	Yes / No / NA
Has the Bedrails Algorithm been followed?	(Yes) / No	(Yes) / No	Yes / No	Yes / No
According to the Bedrails Algorithm are bedrails required / appropriate?	Yes / (No)	Yes / (No)	Yes / No	Yes / No
Bumpers required?	Yes / (No)	Yes / (No)	Yes / No	Yes / No
Initials	RP	SK		

If Yes, commence a Safe Use of Bedrails Care Plan. If No, state reason why bedrails are not required

Safe Use of Bed Rails – Care Plan (BR)

Patient Problem/Need
The patient is at risk of falling out of bed due to (e.g. cognitive or physical condition)
Goal
To promote and maintain patient safety and reduce the risk of falling out of bed

Date	Time	Initial	Planned Nursing Interventions	Discontinued Date/Time	Initial
			Ensure assessment is made on admission, when patient's condition changes, and weekly as a minimum.		
			Ensure rationale for decision made re; the use of bedrails is clearly documented.		
			Consider psychological effects of bedrail usage on patient and where appropriate ensure the patient's consent to their use.		
			Ensure risk of entrapment is minimised by careful positioning of patient prior to operating bedrails.		
			If detachable bedrails used, ensure the gap between the top end bedrail and head of bed is less than 6cm or more than 25cm.		
			If detachable bedrails used, ensure the gap between the bottom end of bedrail and foot of bed is more than 25cm.		
			Continually monitor risk of patient climbing over the top of bedrails and assess the use of bedrails as necessary.		
			Discuss with the patient, the need to share information with other nurses and health care workers re; the use of bedrails, and document within the nursing documentation whether the patient consents to display information at the bed space.		
			Provide Falls/Use of Bedrails information leaflet to patient. Where the patient is incapacitated, ensure that relative/carer is given a leaflet and information about the assessment for bedrails is provided.		
			Ensure all actions, including discussions with relative/ carers are documented.		
			Refer to the Safe Use of Bedrails in Adult In-Patient Settings Guideline for further guidance on the management of bedrails.		
			Re-assess the need for bedrail use at least weekly or as the patient's condition indicates and document on the risk assessment chart.		
			This care plan has been discussed and agreed with the patient as appropriate.		

Moving and Handling

Patient Risk Assessment

All Patients:

- Independently A hoist **must** be used if assistance is required from the floor
- Sliding aids **must** be used bed to trolley/bed unless the patient transfers
- A hoist **must** be used for bathing unless independently mobile
- **Hoists are for lifting patients and must not be used for transport between rooms**

Special Alerts: Date:	14/10	17/10				
Overweight / Obese (BMI definition)						
Very tall (>185cm in height)						
Restricted use of limbs						
Poor standing ability						
Sedation or lethargy						
Irrational behaviour / confusion						
Unable to co-operate						
Acute pain						

Assessment of Risk:

Low Risk: Independently mobile / supervision only required. Aids required should be specified in care plan

Moderate Risk: Requires physical assistance from one or more handlers. Is able to stand or partially bear weight and has no more than one special alert.

High Risk: (a) Is unable to bear weight and requires assistance.
(b) 2 or more special alerts present and requires assistance.

Aids, equipment and a minimum of 2 handlers recommended to move a patient.

Date:	14/10	17/10				
LOW RISK	✓	✓				
MODERATE RISK						
HIGH RISK						
Assessor's Initials	RP	SK				

If a hoist or standing aid is required please specify:

Sling type:		**Size:**		**Manufacturer:**	

Additional Comments:

Moving and Handling Care Plan (MH)

Date:	14/10/23 17/10					
1. Moving in bed:						
a) Independent	a) ✓	✓				
b) Handlers and sliding sheets required to move in bed - specify number of handlers in grid	b)					
c) Specify any additional equipment required in grid	c)					
2. Sitting to Standing:						
a) Independent	a) ✓	✓				
b) Requires assistance from sit/stand to sit? Specify number of handlers in grid	b)					
c) Also requires aids. Specify equipment in grid	c)					
4. Transfers: (chair / wheelchair / commode / toilet / bed)						
a) Independent or with minimal supervision	a) ✓	✓				
b) Assistance required from handlers specify number of handlers in grid.	b)					
c) Equipment required - specify equipment in grid	c)					
4. Adjusting Clothing						
a) Independent or minimal supervision	a) ✓	✓				
b) Can use support/grab rails while assistance is given with clothing	b)					
c) Requires support from Handler(s) while another assists with clothing	c)					
d) Requires equipment, specify equipment in grid	d)					
5. Repositioning in chair / wheelchair:						
a) Independent or minimal supervision	a) ✓	✓				
b) Assistance from handler(s), specify number in grid	b)					
c) Specify other aids or equipment required in grid	c)					
6. Mobilising:	Documented in Mobility Care Plan					
Assessors initials	RP	SK				

If it is decided to stand, transfer or mobilise a patient requiring assistance of more than 2 handlers, without equipment, a detailed assessment outlining the decision making process must be documented in the mobility care plan.

Mobilising – Care Plan (M)

Patient Problem/Need
Patient has restricted mobility/mobility is deteriorating due to.....
Goal
To optimise ability to mobilise safely and maintain independence as much as possible

Date	Time	Initial	Planned Nursing Interventions	Discontinued Date/Time
			Refer to moving and handling risk assessment tool and plan care accordingly.	
			Mobilise/transfer with assistance of one/two handlers.	
			Mobilise/transfer with supervision.	
			Mobilising with appropriate handling equipment and/or aids, please state:-	
			• Walking stick one/two	
			• Tripod/quad	
			• Zimmer frame/rolator	
			• Wheel chair	
			• Hoist aid (specify equipment used)	
			• Other (please specify)	
			Refer to physiotherapist and action specialist requirements.	
			This care plan has been discussed and agreed with the patient and/or carer/relative as appropriate.	

Care Plans and Monitoring Charts Codes for Evaluations

Code	Care Plan / Chart / Ref	Code	Care Plan / Chart / Communication
A	Admitted as emergency		
AHP	Allied health professional (Please specify)		
B	Breathing		
BR	Bed Rails		
BT	Blood Transfusion		
CP	Communication (With patients)		
CF	Communication (With family)		
CC	CAUTI		
CI	Cognitive Impairment		
COI	Control of Infection		
D	Cleansing and Dressing		
E	Elimination		
EM	Emotional wellbeing / anxiety		
F	Falls		
FFN	Food Fluid Nutrition / MUST		
I	Investigations		
M	Mobilising		
MDT	MDT Communication		
MH	Moving and Handling		
N	NEWS		
O	Oral Hygiene		
P	Pain Management		
PA	Pressure Area Care		
Pre Op	Pre operative		
Post Op	Post Operative		
PVC	PVC Chart		
T	TIME Bundle for delirium		
V	Violence and Aggression / Challenging Behaviour		
W	Wound Management		
WR	Ward Round		

Date & Time	Initial Medical/ANP presentation and management plan	Init
14/10/25	SEEN BY DR HODKINSON IMP/ ◦ CP ? MSK ◦ FALL ◦ ↓K+ PLAN/ ◦ CXR ☐ ◦ BLOODS ☑ ◦ SANDO K — ◦ AMAWS ☑ — ◦ TROP 9 & 10 —	

Ward ..... ORANGE .....

Date & Time	Care Plan Code	Record of all care. Including Ward round / MDT and Relative communication	Initials
14/10/23 12:30	PA	**Pressure Ulcer Prevention–Top to Toe skin inspection on admission-Draft Test** Place sticker in nursing notes on admission to ward Admission Date: 14/10/23 Admission Time: 1330 Top to toe skin check – *(please tick or document)* Intact ✓ Patient refused skin check ☐ Not intact ☐ please specify below and expand in nursing notes & care plan STATES SKIN INTACT Pressure relieving mattress activated *(circle appropriate)* – Yes / No / N/A Name/designation RESCONLEIN SN Date & Time 14/10/23 NC22-00361	
	N	NEWS 0 —	
	P	MEDICATION TAKEN AS CHARTED 10mg DIAZEPAM GIVEN AS PER GMANS —	
	M	MOBILISING OFF WARD FOR CIGARETTE —	
	FFN	DIET & FLUID GIVEN —	
	EM	SETTLED IN BED —	RP
		HANDED OVER TO 30 —	RP
14/10/23 1900	N	News as charted	HL
		Independent + self caring	HL
		Diet and fluid tolerated	
		10mg diazepam given as per GMPs	
		Mobilising off ward for cigarette. Smoking	
		disclaimer signed	HL
15/10/23 6:00	N	Observation News 2	
		Patient tachycardic & BP appears ↑ which is ongoing. —	
	M	Independent	JP

Ward 3D

Date & Time	Care Plan Code	Record of all care. Including Ward round / MDT and Relative communication
15/10/23 6:00	F	Independant to toilet
	PVC	Paracetamol as charted
		Scoring on GMANS
		10mg Diazepam as charte
	EM	Slept and settled through the night
15/10/23	N	News as charted.
	M	Mobilised independantly goes off ward for cigarettes
	P	Medication given as per Diazepam given as per GMANS
	E	Independant to toilet
	FFM	Tolerating diet + fluids.
16/10/23 6:15	N	Observation News 1 due to HR 98.
	E	Independent to toilet
	P	Routine medications ~~for~~ as ~~past~~ prescribed
	PVC	Venflon tissued overnight requires new PVC for Paracetamol.
	PA	Skin Intact
		Patient Scored on GMANS overnight as appeared Anxious Patient Refused diazepam. Patient leaving ward for cigarettes via A&E overnight
	EM	Patient hasnt Slept overnight-

Ward ..3D.....

Date & Time	Care Plan Code	Record of all care. Including Ward round / MDT and Relative communication	Initials
1750		News as charted -	
		Medication given as rx	
		Not scoring on GMEWS	
		Independent with ADLS	
		Tolerating diet + fluids	
		Sandd & given	
		If bloods ok ? home tomorrow MB	
17/10/23	E	Continent via toilet	
0200	M	Independantly mobile	
	N	News as charted	
	P	Denies any pain	
	Pa	Care and comfort maintained	
	EM	Settled night, patient declined to sleep in bed opting to sleep in chair.	SK.
0555		Patient walked off Ward with all his belongings. DCN went to look for patient and caught up with him along the back corridor heading to orange zone. Asked patient to stop and talk about whats the matter. Patient shouted "No fuck off" and continued to walk. He then went out the fire escape at the end of the corridor of orange zone. Contacted Security as this door sets alarm off. Called Ward for another member of staff to come look for patient. DCN & NA walked out exit and around the back of maternity before returning via the renal doors. No sight of patient. Returned to	

Ward Care Notes

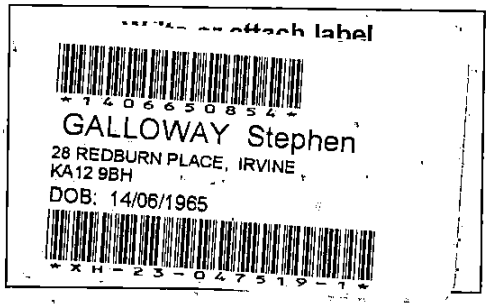
Ward 30

Date & Time	Care Plan Code	Record of all care, Including Ward round / MDT and Relative communication
		Security office who cant see patient on any of the cameras. Patient was wearing Blue jeans, black trainers Black Jacket glasses. He was carrying 2 bags one of which was black. Police Scotland Contacted and Informed. Ref NO# 0457 17/10/22.

NHS Ayrshire & Arran

SMOKE FREE GROUNDS POLICY: DISCLAIMER

Please note as part of the nursing admission documentation all patients who are smokers or e-cigarette users should be offered a referral to the Quit Your Way smoking cessation service via Trakcare and this should be logged in the documentation.



Patient Disclaimer

Hospital:	Thrase
Ward/Station/Dept:	3D
Patient Name:	S Galloway

I _____(print name) have been provided with information regarding the management of smoking in hospital in compliance with the NHS Ayrshire & Arran Smoke Free Grounds Policy and I understand that I am not permitted to smoke anywhere on NHS Ayrshire & Arran grounds. I am aware of the Prohibition of Smoking Outside Hospital Buildings (Scotland) Regulations 2022 legislation and that I may be fined up to £1000 if found smoking within 15 metres of a hospital building.

I have read and understood this information. I have been advised against leaving the ward to smoke. I understand that there are risks associated with leaving the ward/department. In particular I understand that my decision will affect the medical attention I receive and that NHS Ayrshire & Arran cannot provide medical care and attention to me whilst I am absent from the ward/department. I therefore accept that the staff cannot be responsible for my care whilst I am absent from the ward and hospital grounds.

Patient Signature:	S Galloway	Witness Signature:	H Lynch
Date:	14/10/23	Date:	14/10/23
Time:	1715	Time:	1715

PLEASE FILE THIS FORM IN THE NURSING NOTES ENSURING CIRCUMSTANCES ARE FULLY DOCUMENTED

NHS Ayrshire & Arran

NHS Ayrshire & Arran Care and Comfort Round

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

Registered Nurse responsible for patient should prescribe frequency as per patient's greatest need, to provide individualised person centred care.
Escalate any concerns to Staff Nurse responsible for patient.
Min 12hrly *only* if patient independent with ADLs
Weigh Patient every 7 days Recorded Weight

Date/Time	Name	Designation	Initials	Circle prescribed hourly frequency
12/10/23				1hr 2 hr 3hr. (4hr) 12hr
				1hr 2 hr 3hr 4hr 12hr.

Date/Time of Care Rounding 24 hr format (0000 -2400)																
	1/1/22	1410	1510	1510	1510	1510	1610						1610	1610	1710
	08DD	1045	0625	0930	1400	1910	0215	0745	1425	1720	2020			0036	0500

Generic Codes : Y- Yes N – No NA-not applicable NT – No Thanks S – Sleeping O – Off ward I - Independent

Pressure area care should take place at a maximum of 4 hourly intervals – Consider if pain relief required prior to moving

Pressure Ulcer Care If new grade ≥2 PU identified complete DATIX

Skin Inspection completed?	Y	1410													
Skin checked under devices?	Y														
Area of skin damage codes *If multiple document on reverse*	RHL – Right Heel LHL – Left Heel	RHP – Right Hip LHP – Left Hip			C- Coccyx B – Buttocks		SP – Spine OT – Other				O – Occiput (back of head) M- Multiple		N – None		
Area of skin damage	C														
Condition of Skin Record Codes	SR – Slowly Reactive (3-6secs) D –Discolouration U- Pressure Ulcer M – Moisture E- Excoriation N – Normal Briskly Reactive (1-2 secs)														
Condition of Skin	SR														
Skin Surface pressure relieving equipment in use codes	HA – Hybrid activated HNA – Hybrid not activated				C – Chair Cushion PB – Prolevo boots				OM – Other (document on reverse) HS – Heel Safe Pad						
Skin Surface pressure relieving equipment in use	HNA														
Keep Moving- Record change of patient position	R – Right Side L – Left Side B – Back C-Chair to Stand BC-Bed to chair I – Independent Recommend 30 degree lateral tilt and use of sliding sheets														
Record change of position	R														
Sliding sheet used	Y														

Personal Hygiene I – Independent A – Assistance given B- Basin S- Shower BB – Bed bath FI – full immersion bath

Personal Hygiene	BB														

Elimination

Patient toilet facility codes	I – Independent A – Assistance given BP- Bed Pan C- Commode NA – Not applicable														
Offer patient toilet facility	A														
Continence Codes	IU – Incontinent Urine IF – Incontinent Faeces UC – Urinary Catheter S – Stoma PU – Passed Urine BO – Bowels open NA – Not applicable														
Bowels open/ passed urine?	IU														
Bristol Stool Score (if known)	NA														
Barrier product applied?	Y														

Document skin care intervention and barrier product used in evaluation section on reverse

Food, Fluid and Nutrition

Has appropriate assistance with eating and drinking been provided?	Y														
Nutritional Supplements given and encouraged	Y														
Fluid is within easy reach and refreshed and offered	Y														

ensure FFN given is appropriate level *Update Nutritional Intake Record Chart & Fluid Intake/Output chart if applicable

Oral hygiene carried out (12hrly) (Increase to 2hrly if NBM)	Y														
Is the nurse call buzzer working and within reach of the patient?	Y														

If unable to use buzzer, commence 1 hourly care and comfort round

Falls If HLS required, complete appropriate documentation

How many bed rails in use?	2														
Trolley/bed at lowest level	Y														
HLS Codes	S – Standard CO – Cohort CT Constant (provide meaningful activity)														
Level of Higher Level Supervision in place	CO														
Is the patient more confused, drowsy or agitated? Think Delirium	N														
Encourage to mobilise (ie marching feet, sit to stand)	Y														
Walking aid within reach Aid in use.....	NA														
Ensure environment free of any trip hazards	Y														
Escalate all concerns	Y														
Completed by (Initial)	KP														

Daily Evaluation of HCSW Care Delivery & Escalation Record

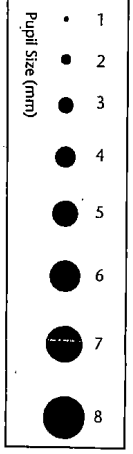
Date	Evaluation and Escalation Record	Name
01/01/22	*Example* – Identified Concern – Slowly reactive area at coccyx	
0800	Escalated to SN. Positional change nursed on alternate side (30 degree tilt) hybrid mattress activated, barrier cream	
	applied. Personal Hygiene attended to using Senset foam, incontinence products replaced. Request for care	K.Perry
	rounding frequency to be increased to 3 hourly. Assisted wash given.	HCSW
1410	Skin Check refused - care + comfort Cy Daily	

Glasgow Coma Scale

Date:		11/1																												
Time:		11.00																												
Eyes Open	Spontaneous	4																												
	To speech	3																												
	To pain	2																												
	None	1																												
Best Verbal Response	Orientated	5																												
	Confused	4																												
	Inapp. words	3																												
	Incomp. sounds	2																												
	None	1																												
Best motor response	Obeys commands	6																												
	Localise pain	5																												
	Withdrawal to pain	4																												
	Abnorm. flexion to pain	3																												
	Extension to pain	2																												
	None	1																												
GCS TOTAL																														
PUPILS	R Size																													
	R Reaction																													
	L Size																													
	L Reaction																													
LIMB MOVEMENT ARMS	Normal power																													
	Mild weakness																													
	Severe weakness																													
	Abnormal flexion																													
	Extension																													
	No response																													
LIMB MOVEMENT LEGS	Normal power																													
	Mild weakness																													
	Severe weakness																													
	Extension																													
	No response																													
Initials		AB																												

Pupil Reaction and size

s = sluggish
+ = reaction
- = no reaction



I	Identify self/area/patient.
S	Situation - what is your concern?
B	Background - relevant Hx/reason for admission.
A	Assessment - A-E findings/NEWS2 score.
R	Recommendation - what do you need & when.

NEWS > 5 THINK SEPSIS Apply SEPSIS 6 within 1 hour

1. Give oxygen to target saturation >94% (COPD 88-92%)
2. IV fluids up to 20ml/kg
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output and fluid balance chart

NHS Ayrshire & Arran NEWS – National Early Warning Score

NHS Ayrshire & Arran

Obs 7.

1406650854
GALLOWAY Stephen
28 REDBURN PLACE, IRVINE
KA12 9BH
DOB: 14/06/1965
XH-23-047519-1

	Ward	Date	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

	Resp rate	BP	HR
Acceptable parameter's			
Dr/ANP initials			
Date			
Dr/ANP discontinue date/sign			

Sp02 Scale 2 Target 88-92%
Signature:
Print Name:
Dr/ANP initials ONLY:
Date:

Patient on home oxygen Y☐ N☐
If yes, add details of oxygen therapy

Document all actions and interventions

NEWS 0	**NEWS 1-4**	**NEWS 5-6 or 3 in one parameter**	**NEWS 7 or more**
	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
Min 12 Hourly Observations	Min 4 Hourly Observation	Min Hourly Observations	Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	Think Sepsis if Suspicion of Infection	Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS2

Following MDT discussion, it has been agreed that this patient no longer has a requirement for NEWS2

Responsible Clinician: Print Name .....

Designation:.....

Date: ..... Time: .....

NEWS2

NHS Ayrshire & Arran

Write or attach label

HCR
CHI: 1406650854
Surna Galloway, Stephen
Forer 28 Redburn Place
Addre Irvine
..... KA12 9BH
..... 14/06/1965
Date c Dr TG Miller
MRN: XHI468158

Endoscopy Unit - Crosshouse Hospital

Patient Care Pathway

Proposed Procedure ..... OGD ..... Patient Preferred Name ..... Steve .....

Date of Admission ..... Pre Admission .....

Consultant ..... DrTAHA ..... Pre Admission Nurse .....

Previous Endoscopy (Yes) / No Religion .....

Contact Name ..... Relationship .....

Telephone number ..... Phoned Yes/ No

Does patient have an escort Yes / No Waiting / Returning

Time returning/phoning .....

Type of transport home Car Amb Taxi Other ..... Bus alone .....

Responsible adult to take home? Yes / No / Not required

Responsible adult at home? Yes / No Who? .....

Warfarin	Yes / (No)	INR	Date/time .....
Plavix/Aspirin	Yes / (No)	.....	
Prosthetic Heart valve	Yes / (No)	.....	
Pacemaker	Yes / (No)	.....	
ICD	Yes / (No)	Cardiology Informed	Yes / No
Latex Allergy	Yes / (No)	.....	
Diabetes	~~Type I / Type II~~ NO	BM	Date/time .....

Notes Meets Scats Criteria
Covid not detected
Temp 36.4

MEDICAL/SURGICAL HISTORY

Steady
weight ..... kg

Pregnant Yes / ~~No~~ LMP N/A
Liver Disease Yes / No .....
Hypertension Yes / No .....
Anaemia Yes / No .....
(or other blood problems)
Heart Disease (Yes) / No MI x4
Respiratory Problems (Yes) / No COPD
Surgery (Yes) / ~~No~~
Others (specify) Tendon repair Rt hand. ? cysts in lungs.
Reasons for attending Endoscopy ? UGI / varices.

Glaucoma Yes / ~~No~~
CVA Yes / ~~No~~
Epilepsy Yes / ~~No~~
~~O~~/Arthritis (Yes) / No Generalised
ALT
~~GTN~~ anxiety with thyroid + Malaise. depression.
Prev GTN spray - no longer.

CURRENT MEDICATIONS

1. Ventolin 2. Spiriva 9. ..... 10. .....
3. Thiamine 4. lansoprazole 11. ..... 12. .....
5. amitriptyline 6. Co-Codamol *ALLERGIES*
7. tadafil 8. Propanolol NKDA

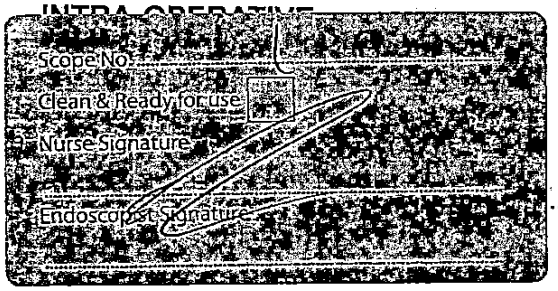
PRE-PROCEDURE CHECKLIST

Fasted (Yes) / No Casenotes ~~Yes~~ / No CJD questionnaire Completed (Yes) No
Consent ~~Yes~~ / No Xrays Yes / ~~No~~ Slip, Trip assessment Yes / No / ~~Not Required~~
Name Band ~~Yes~~ / No Piercings Yes / ~~No~~
Jewellery Removed and retained by patient Yes / No / Other N/A. Covered with tape
Metal Implants (Yes) / ~~No~~ where? Lt cheek. yrs ago
~~Bowel Prep~~ ~~Picolax~~ N/A ~~Enema~~ ~~Kleenprep~~ ~~Senna~~ ~~Moviprep~~ ~~Other~~
Observations - PRE-ADMISSION ONLY 02 sat..... P..... BP.....
Patients understanding of procedure ~~Full~~ Partial Comment .....

Procedure Explained	(Yes)
Sedation options discussed	(Yes)
2nd stage waiting time discussed	(Yes)

Previous Patient (Yes) / No Fasted Fluids Yes / No
Emotional factors / anxieties / comments

INTRA-OPERATIVE



H CHI: 1406650854
C Galloway, Stephen
S 28 Redburn Place
Irvine
Fo KA12 9BH
Ac 14/06/1965
Dr TG Miller
MRN: XHI468158
Date of Birth

PREPARATION FOR PROCEDURE

Dentures removed Yes / No n/a Loose teeth Yes / No n/a

Hearing aid removed Yes / No n/a Glasses removed Yes / No n/a

IV Cannula Yes / No n/a Site ..... By Whom .....

Medication	Dose	Route	Time	Prescribed by	Given by
Midazolam					
Hyoscine					
Pethidine					
Lignocaine throat spray	10mg	Oral	1345	HBN 20168	Dr Rutter
Lignocaine 2%					
Oxygen					
Saline 0.9%					

ENDOSCOPY PROCEDURE PERFORMED ..... OGD

Specimens taken

Biopsies ..... Polyps ..... Retrieved / To be retrieved

.... Aspirate

H Pylori test (Clo) Photograph Brush

Other .....

Diathermy plate Yes / No Pad site ..... Skin intact Yes / No

Time procedure commenced 1345 completed 1350

Review discharge 15mins 30mins 1 hour Rev by doctor

Diet instructions Normal diet Soft diet Fluids only Nil by mouth until .....

Endoscopists follow on instructions .....

.....

Nurse Signature ..... Designation SN Date 19/5/24

OBSERVATION CHART

	Admission pre-op		Intra-procedure				Recovery				
Time/pulse BP	1445		1544				1550				
210											
200											
190											
180											
170											
160											
150			151				151				
140											
130	136										
120											
110											
100											
90	96										
80			83				83				
70											
60											
50											
40	P 85		P 87				P 82				
02 therapy	Air		91-				98%				
02 sats	98%		97%				91-				
comfort score	0		0				0				
sedation score	0		0				0				
pain score	0		0				0				

COMFORT SCORE - during procedure

0 No discomfort - resting comfortably throughout
1 one or two episodes of mild discomfort, well tolerated
2 > two episodes of discomfort, adequately tolerated
3 significant discomfort, experienced several times during procedure
4 extreme discomfort frequently during procedure

SEDATION SCORE

0 None (patient alert)
1 Mild (occasionally drowsy, easy to rouse)
2 Moderate (frequently drowsy, easy to rouse)
3 Severe, Somnolent (difficult to rouse)

PAIN SCORE - post procedure

0 No pain at rest; No pain on movement
1 No pain at rest; slight pain on movement
2 Intermittent pain at rest; slight pain on movement
3 Intermittent pain at rest; moderate pain movement
4 Continuous pain at rest; severe pain on movement

Instrument stickers

PATIENT DISCHARGE

HCR N CHI: 1406650854
CHI Nc Galloway, Stephen
Surnan 28 Redburn Place
Irvine
Forena KA12 9BH
Addres 14/06/1965
..... Dr TG Miller
Date of MRN: XHI468158

Time due to leave department 1645

Time left department 1600

Alert and orientated	(Yes) / No	Dentures returned	Yes / No
Diet/Fluids tolerated	Yes / No (will get one none)	Glasses returned	(Yes) / No
Flatus passed	Yes / No none	Property returned	(Yes) / No
Cannula removed	~~Yes / No~~	Transport arranged	(Yes) / No
Pacemaker assessment	~~Yes / Not Required~~	Pain Score	(0) 1 2 3
ICD turned on	Yes / ~~Not Required~~	Sedation Score	(0) 1 2 3
Discharge advice discussed in private?	(Yes) / No	Patient assessed as ready for discharge?	(Yes) / No
Discharge letter given?	(Yes) / No	Patient feels ready for discharge?	(Yes) / No

Comments..... feels fit for discharge

Spoken to by.....

Patient education none required / yes (specify)

.....

.....

Clinic appointment:- has one for ..... to be made for .....

To be rescoped Yes / No details:.....

Other follow-up.....

DISCHARGED / HOME (circle as required)

Alone / Accompanied (by whom) ..... self .....

By Ambulance Yes / No

Transfer to Ward Yes / No Which ward.....

Personal effects transferred Dentures Yes / No
Glasses Yes / No
Clothing Yes / No
Valuables Yes / No
Other.....

Additional comments .....

.....

Nurse Specialist Referral? **Yes / No**

Specify .....

Blue oesophageal referral form completed (sent to audit office) Yes / No

Red Colorectal Form completed Sent and filed as per local policy Yes / No

Additional comments .....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

Other comments .....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

Print name designation initials signature date

1.

2.

Nurse Signature .....Designation .....Date.....

NHS Ayrshire & Arran

Risk Screening Questionnaire For TSE, CJD and vCJD involving low and medium risk tissue.

Write or attach label

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

Planned Procedure:	CJD

Questions 1 – 2 to be completed for all patients	Yes	No
1. Have you ever been notified that you are at risk of CJD or vCJD for public health purposes?		✓
2. What is the tissue risk of the procedure? (see table overleaf) High ☐ Medium ☐ Low ☐ If tissue risk is high, please use Risk Screening Questionnaire For TSE, CJD and vCJD involving high risk tissue.		

If the patient answers yes question 1, please take additional precautions for any instruments which have been or may come in contact with tissue of high or medium level infectivity.

If the patient answers no to question 1, there is no need to take any additional precautions

For further information, please contact Infection Control

Patient Risk (Q1)	Tissue Risk (Q2)		
	Low	Medium	High
Low	No Restrictions	No Restrictions	No Restrictions
High	No Restrictions	Single use instruments or Quarantine until advice sought from Infection Control	Single use instruments or Quarantine until advice sought from Infection Control

Name: C Roberts	Designation: SIN
Signature: C Roberts	Date: 19/5/202.

The vCJD questionnaire is to be used for all patients undergoing surgical or endoscopic procedures.

Table 1:- Examples of tissues with high and medium level infectivity

High	Medium
Brain Spinal cord Dura mater – implanted dura mater grafts prior to 1992 Cranial Nerves (specifically the entire optic nerve; only the intracranial components of the other cranial nerves) Cranial nerve ganglia Posterior eye (posterior hyaloid face, retina, retinal pigment epithelium, choroids, subretinal fluid, optic nerve) Pituitary gland	Spinal ganglia Anterior eye and cornea Olfactory epithelium Tonsil Appendix Spleen Thymus Fixed lymphoid tissue

Table 2:- Human TSE Diseases

Idiopathic Diseases	Sporadic CJD Sporadic Fatal Insomnia
Familial Diseases	Familial CJD, Gerstmann-Sträussler-Scheinker (GSS) Disease and Fatal Familial Insomnia
Acquired Diseases	Human agents: Kuru and iatrogenic CJD Bovine agent: Variant CJD

Notes on questions

	Question to Patient	Note to clinician
1	Have you ever been notified that you are at risk of CJD for public health purposes? If yes please specify	The CJD Incidents Panel has identified a number of individuals who are potentially at risk of CJD or vCJD for Public Health Purposes: If patient answers **NO**, surgery can proceed using normal infection control procedures. If patient answers **YES**, special infection control precautions should be taken. Contact infection control for further advice. If the patient is **unable to respond**, surgery can proceed using normal infection control procedures unless the procedure is likely to lead to contact with **high risk** tissue.

Patients response	**Action**
No to questions 1	Surgery / can proceed using normal infection control procedures.
Yes to questions 1	Further investigation into the nature of the patient's CJD risk should be undertaken by medical staff. The patient's CJD risk should be confirmed or rejected. Confirmation or rejection of CJD risk should be recorded in the patient's medical notes for future reference. If the patient is found to be at risk of CJD of vCJD following investigation, or the risk status is unknown at the time of the procedure, special infection control precautions should be taken. Contact infection control team for advice. If the patient is found to be at risk of CJD or vCJD they should be referred to their GP, who will need to inform them that they are at risk of CJD or vCJD and provide them with further information and advice. This is available from the CJD Incidents Panel: http://www.hpa.org.uk/infections/topics_az/cjd/information_documents.htm
Unable to respond to questions 1	Surgery or endoscopy should proceed using normal infection prevention and control procedures **unless** the procedure is likely to lead to contact with high risk tissue. If this is the case, please refer to the additional recommendations for high risk procedures. Contact infection control team for further advice.

CHI: 1406650854
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GASTROINTESTINAL ENDOSC

Please complete and bring when you attend.

1 Have you had past serious illnesses an... YES/NO

Year	Hospital	Name of Condition	Treatment

---

2 Do you have, or have had, any of the following:-

Diabetes or sugar in the urine?	YES/NO
High blood pressure?	DONT KNOW YES/NO
Heart disease or rheumatic fever?	YES/NO
Bronchitis, asthma or other lung problems?	YES/NO
Convulsions or fits?	YES/NO
Prolonged mental upset or faints?	YES/NO
Arthritis or prolonged muscle disease?	YES/NO
Severe or prolonged trouble with your bowels or urine?	YES/NO
Anaemia or other blood problems?	YES/NO
Allergies or reactions to medicines, tablets, strapping or applications	YES/NO

---

3 Does any illness run in your family? YES/NO
Please give details.

Have any of your family had anaesthetic problems? YES/NO
Do any of your family bleed or bruise excessively? YES/NO

---

4 Are you taking any pills or medicines, or having injections now or in the last 2 months? YES/NO
Give the names if you can (do not worry about spelling)

If in doubt bring them with you.

---

5 Do you have serious problems with your sight, hearing, or use of limbs? YES/NO

---

6 For women only - Do you think you are pregnant? YES/NO

---

7 For children only - Has there been any serious problem in physical or mental development? YES/NO

DAY SURGERY SBAR HANDOVER

PATIENT NAME stephen Galloway 53.

SITUATION	BACKGROUND
Transferred from: DSU Referring nurse: Tracy Flitcroft Speciality: Endocrine. Allocated consultant: ~~Dr McCauley~~. Dr Tahra. Day. TAG insitu G4 Aware -	Reason for admission: ?chest infection, cough ?SOB. Date of admission: 21-01-19. PMH: Anxiety Depression Hypertension. Alc x2 Allergies/alerts: NIL Home/social circumstances: Lives Alone. NOK: Hugh Galloway Brother
ASSESSMENT	**RECOMMENDATIONS**
Diagnosis:	Review or criteria led discharge? RV.
Investigations/treatment carried out:	Estimated discharge date:
	IDL completed/sent to pharmacy Y/N? N
Investigations/treatment requested: bloods tomorrow oral abx amikacin + IV parbinex. NEWS: 2 SpO2 96% pulse 91. 4 AT SCORE	Homecare Y/N? Confirmed Y/N? N.
	Transport home: Ambulance/patient transport? Reference no:
ADL/mobility/continence/assistance/skin bundle? Independent.	Physio/OT/Socialwork input?
Falls risk? NO	SEND MEDS!!!

NHS
Ayrshire & Arran

Ayrshire Assessment and Management of Alcohol Withdrawal Syndrome (AAMAWS)

GALLOWAY Stephen
28 REDBURN PLACE, IRVINE
KA12 9BH
DOB: 14/06/1965

STEP 1: DETERMINE ALCOHOL HISTORY (to be completed by the prescriber)

Estimated Weekly Alcohol Units: _____ (Daily Units x 7 days) excessive weekly consumption (♂& ♀ >14 units/week)

Estimated day/time of last drink: _____ (if > 5 days, re-consider alcohol withdrawal status)

Presents with (or previous history) Alcohol Related Seizure **Yes** ☐ **No** ☐

Presents with (or previous history) Delirium Tremens **Yes** ☐ **No** ☐

Number of Units = ABV (%) x Volume (litres) e.g.

A bottle of wine (750mls) which is 12% ABV = 12 x 0.75 = 9 Units

A glass of wine (200mls) which is 12% ABV = 12 x 0.2 = 2.4 Units

ALCOHOL SCREENING TOOL *("Audit PC")*

	SCORE					
	0	1	2	3	4	Total
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times a week	4 or more times a week	
2. How many **units of alcohol** do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often during the last year have you found that you were not able to stop drinking once you had started	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you failed to do what was normally expected of you because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes but not in the past year		Yes during the past year	
TOTAL SCORE:						

0-5:Responsible drinking pattern **6-10:Hazardous drinking pattern**
11-14:Harmful drinking pattern **15-20:Dependent drinking pattern**

If Audit PC score indicates that the individual is drinking at harmful / hazardous / dependent levels referral to be made to Alcohol liaison.

STEP 2: DETERMINE TREATMENT OPTION FOR THE MANAGEMENT OF ALCOHOL WITHDRAWAL SYNDROME (to be completed by the prescriber)

RISK OF SEVERE ALCOHOL WITHDRAWAL

Any 2 of the following:

- Presents with or has had previous withdrawal seizures ☐
- Previous episode of Delirium Tremens ☐
- Clinically has alcohol dependence / scoring 15 or above on Alcohol ScreeningTool *Audit PC* (see step 1 above) ☐
- High initial symptom score (GMAWS > 8) ☐
  (Do not use scoring tool if patient intoxicated or < 8 hours since last drink)

YES → FIXED DOSE TREATMENT **PLUS** SYMPTOM TRIGGERED TREATMENT **(standard or reduced dose diazepam or lorazepam)**

NO → SYMPTOM TRIGGERED TREATMENT **(standard or reduced dose diazepam or lorazepam)**

SELECT TREATMENT OPTION:

NO TREATMENT ☐ **SYMPTOM TRIGGERED ONLY** ☑

FIXED DOSE PLUS SYMPTOM TRIGGERED ☐

Treatment must be prescribed on HEPMA and prescription chart overleaf

NOTE! Fixed dose & symptom triggered dosing must be no less than 1 hour apart

NHS
Ayrshire
& Arran

PRESCRIBING GUIDANCE

DOSE EQUIVALENCE

APPROXIMATE ORAL BENZODIAZEPINE EQUIVALENCE: 10mg diazepam = 1mg lorazepam

ORAL to IM / IV BENZODIAZEPINE DOSE EQUIVALENCE: IM / IV benzodiazepine dose equivalent is half the oral dose.

Example: patient requires diazepam 20mg four times per day orally
Equivalent dose of IM / IV diazepam would be 10mg four times per day
Equivalent dose of oral lorazepam would be 2mg four times per day
Equivalent dose of IM/IV lorazepam would be 1mg four times per day

EXCEPTIONAL PATIENT GROUPS:

- Actual or suspected head injury
- Hepatic impairment (patients with elevated Bilirubin or Prothrombin Time who are at risk of benzodiazepine accumulation)
- Other co-morbidities where the patient is at risk of over-sedation on respiratory depression e.g Respiratory or cerebrovascular disease, reduced Glasgow Coma Scale

Consider the use of oral Lorazepam in these exceptional patient groups in a symptom triggered fashion: dose should be based on the patient's GMAWS score.

ELDERLY PATIENTS (>65 years) +/OR PATIENTS WITH CrCl <20 ml/min:

In general *half the dose of benzodiazepines* is usually recommended (the need for this is dependent on overall fitness, co-morbidity and degree of frailty). To minimise adverse effects associated with benzodiazepines (e.g. over sedation, confusion and ataxia) it is important to bear in mind the *start low and go-slow* rule in these patient groups (start with lower doses, monitor frequently and increase if necessary as symptoms suggest).

PATIENTS UNABLE TO TOLERATE ORAL MEDICATION

Patients unable to tolerate oral medication may receive intravenous therapy as an alternative at **50% of the oral dose** in the first instance, and response assessed. Please consider benzodiazepine dose equivalences (see above).

MONITORING

All patients should be closely observed for signs of over-sedation with regular observations. Exceptional Patient Groups (see above), patients with Severe Withdrawal and patients requiring Intravenous or Intramuscular Sedation require close monitoring (NEWS). Please refer to the NHS Ayrshire & Arran Clinical Guideline G078 for further information on the care of patients requiring a Higher Level of Supervision in Acute Hospital Settings.

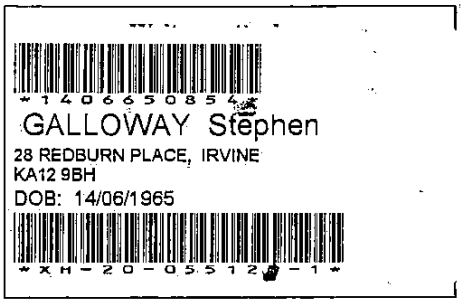
PABRINEX ADMINISTRATION

Please refer to ADTC 92 In-patient Guideline for treatment of Thiamine Deficiency in patients with Chronic Alcohol misuse using Pabrinex® Injection. Patients at risk or with suspected of Wernicke's Encephalopathy should be prescribed high dose parenteral Pabrinex® 2 pairs three times daily intravenously for 3-5 days or until clinical improvement ceases.

DISCHARGE PLANNING

Patients should not be routinely discharged until detox process is complete.

NHS
Ayrshire & Arran


GALLOWAY Stephen
28 REDBURN PLACE, IRVINE
KA12 9BH
DOB: 14/06/1965

PATIENT PROFILE

Please complete below when patient is admitted or transferred to your clinical area

	Admission		Transfer 1		Transfer 2		Transfer 3	
Hospital	X house							
Ward	CAU							
Consultant	Dr Weir							
Date / Time	13/12/20	09:15						
Relative Informed	Yes	No	Yes	No	Yes	No	Yes	No
ID Band in situ	(Yes)	No	Yes	No	Yes	No	Yes	No
CRA Completed *	(Yes)	No	Yes	No	Yes	No	Yes	No
Completed By - Signature	SM							

The Patient Profile can be used for patients with ongoing regular treatment i.e. for a course of therapy or weekly blood transfusion, however if there is a gap of more than 6 weeks since last attendance update lifestyle assessment (P5)

*If the patient is readmitted or transferred between hospitals an additional MRSA/CRA (P10 must be completed. Additional forms can be obtained from the infection control AthenA site.

This profile can also be used for readmission within 3 c
sessments.

Patient's Property – Where possible send

You are asked to keep belongings/valuables to a mi
property belonging to you not handed over for safe
aids, dentures and other personal items and valu
opportunity or given to the nurse if this is not possible.

Signature of Patient / Significant Other:.....

Property handed over for Safe Keeping: Yes ☐

Date taken to Cashier: ..... Cash &

Property handed over for safe keeping

PLACE VALUABLES STICKER HERI

Date Returned:

COVID-19 NHS Ayrshire & Arran

Patients CHI:

Patients name:

MEDIUM RISK HIGH RISK

Date swabbed:
(SIGN 15/12/2020)

Decision **NOT TO SWAB:**
(SIGN)

Result date:

Positive ☐ **Negative** ☐

Is there a person shielding/ high risk at the address you are being discharged home too? ☐

Start date of isolation:

End date of isolation:

NC20-00179

Clinical Team Signatures

All staff completing this documentation MUST complete this section

Name (Block Caps)	Profession	Ward/ Page No	Signature	Initials
SOPHIE MAXWELL	STN	CAU		SM
SARA GOBAT	SJN	CAU		SG
MEDIATRIX NWOSU	SN	CAU		MN

Colour Codes for sections within			
	Personal Details		Care Plans
	Lifestyle Assessment		MDT Discharge Plan
	Risk Assessment		Ward Care Notes

Personal Details

Prefers to be known as: Stevie	Age: 55
Receiving Consultant Dr Weir	Allocated Consultant
From where: ED	Accompanied by: ED staff
Emergency ☐ Elective ☐	Patient Contact Number: 07468337186
Occupation Unemployed	

Have you or a member of your family ever served in the Armed Forces? Yes ☐ No ☑ - **For referrals to Defence Medical Welfare Service please contact** 07377 722638 or email smurphy@dmws.org.uk

Reason for Admission

DT

Alcohol withdrawl, hallucinating.

Patient and/or Carers Accounts

Next of Kin/First/Contact/Significant other		Second contact/significant other	
Name Hugh Galloway		Name Sophie Galloway (17)	
Address		Address 28 Redburnplace Irvine KA12 9JH	
Relationship to patient:	Brother	Relationship to patient:	Daughter
Contact No(s) Home:		Contact No(s) Home:	
Mobile:		Mobile:	07802705720
Aware of Admission	Yes ☐ No ☑	Aware of Admission	Yes ☑ No ☐
Contact Overnight	Yes ☐ No ☐	Contact Overnight	Yes ☑ No ☐

Patient gives consent to share information with whom? ~~Husband~~ Daughter only

Spiritual or religious needs

Do you have any spiritual or religious needs whilst in hospital? (please state) Yes ☐ No ☑	Specify needs or cultural practices that place limitations on the patients care (please state)
Do you wish your details to be passed to the hospital chaplaincy service? Yes ☐ No ☑	

Home Circumstances on admission

		Living arrangements	
Do you live alone?	Yes ☐ No ☑	Type of house	Masonette
With dependent partner?	Yes ☐ No ☐	Sheltered Housing	Yes ☐ No ☑
With independent partner/family?	Yes ☑ No ☐	How many steps at entrance?	37
Do you have a carer?	Yes ☐ No ☑	How many stairs inside?	13
Family ☐ Private ☐ Local Authority ☐		Toilet	Upstairs ☑ Downstairs ☐
Does carer require additional support? (Consider referral to social work)	Yes ☐ No ☐	Bedrooms	Upstairs ☑ Downstairs ☐
		Bannister	Yes ☐ No ☑

Personal Details

Are you a carer? Yes ☐ No ☑ Please specify Children ☐ Elderly relative ☐ Other ☐							
Who is caring for them currently?							
Family	☐	Social Worker	☐	Neighbour	☐	Nursing Home	☐
Respite Centre	☐	Other ☐					

Community Services in use:		Frequency	Informed of Admission	Informed by/Comments
Home Care provided	Yes ☐ No ☑		Yes ☐ No ☐	
Community Alarm	Yes ☐ No ☑		Yes ☐ No ☐	
Day Hospital	Yes ☐ No ☑		Yes ☐ No ☐	
Community Nurse	Yes ☐ No ☑		Yes ☐ No ☐	
Community Mental Health Nurse	Yes ☐ No ☑		Yes ☐ No ☐	
Learning Disability Nurse	Yes ☐ No ☑		Yes ☐ No ☐	
Visited by Specialist Nurse	Yes ☐ No ☐		Yes ☐ No ☐	Please specify
Does the patient have an ACP?	Yes ☐ No ☐	Ensure it is visible in notes		

Previous Medical History

Details	Dates
Alcohol XS	
COPD	
GI Bleed	
MI	
Anxiety	
Depression	

Medications

Is the patient prescribed regular medications?	Yes ☑ No ☐	Have they brought them in?	Yes ☐ No ☑
Retained in the ward?	Yes ☐ No ☐	Given to relatives?	Yes ☐ No ☐

Is patient on any high risk medications? Please tick the box below

Epilepsy	Asthma	Insulin	Anticoagulation	Controlled drugs	Any others note below

Thiamine, Inhaler

Pre-Admission Status Independent ☑ Prompting required ☐ Assistance required ☐

Drug Allergies:	**Other Allergies:** None Known ☑

Informed Consent and Capacity

While undertaking the patient's clinical assessment, if you have any concerns regarding the patient's capacity and ability to make healthcare decisions refer to medical staff for **assessment and treatment plan** under the Adults With Incapacity (Scotland) Act 2000 and document your actions within the nursing notes. Refer to the Consent policy for further guidance.

Relatives and carers cannot make decisions for patients except in certain circumstances where they hold Welfare Guardianship or Power of Attorney extending to health care decisions under the Adults With Incapacity (Scotland) Act 2000.

Advanced Statement	Yes ☐ No ☐	Guardianship details	Yes ☐ No ☐	Please note name
Power of Attorney details	Yes ☐ No ☐	Financial ☐ Please note name	Welfare ☐ Please note name	
"Getting to know me" in use	Yes ☐ No ☐	If yes to any of the above obtain a copy of the relevant document		

Adult Support and Protection – 3 point criteria Please see ASP toolkit

If you have a concern about an adult who you believe is or may be at risk of harm complete an ASP/Concern referral. **ASP / Concern referral submitted Yes ☐ No ☐ Date** _____

Referral information can be found on ward A S P folder or AthenA Adult Support and Protection site

4AT		Circle score		
To be completed on all patients over 65 or if appropriate or if the patient has suspected delirium Ask the patient the following questions : (4AT)		1st Assess	2nd Assess	3rd Assess
		Date 13/12/20	Date	Date
Alertness	Normal	(0)	0	0
	Mild Sleepiness for< 10 seconds after waking then normal	0	0	0
	Clearly abnormal	4	4	4
4AT	Age, Date of Birth, place of birth, current year			
	No mistake	(0)	0	0
	1 mistake	1	1	1
	2 mistakes or untestable	2	2	2
Attention– Instruct patient to list months in reverse order starting at December				
	Lists 7> correctly	(0)	0	0
	Starts but lists <7 or refuses to start	1	1	1
	Untestable (cannot start became unwell, drowsy or inattentive)	2	2	2
Acute	Change or fluctuating course - evidence of significant change or fluctuation in mental status within the last 2 weeks and still persisting in the last 24 hours			
	No	0	0	0
	Yes	(4)	4	4
	Total	4		
	Sign	SM		

If 4AT > 4 commence TIME bundle. **Please reassess if there is a change in clinical condition.**

If no 4AT carried out please state reason here.....

Driving Status	Do you Drive? Yes ☐ No ☑	
Alcohol Use 2L a day	Units per week 2L a day	- None for past 5 days
	Suitable for alcohol brief intervention?	Yes ☐ No ☐ NA ☐
	Currently in Treatment	Yes ☐ No ☐ NA ☐
	Refer to alcohol liaison team?	Yes ☐ No ☐ NA ☐
Substance misuse	Substance misuse issues? If yes, give details:	Yes ☐ No ☑ NA ☐
	Currently in treatment	Yes ☐ No ☑ NA ☐
	Refer to substance misuse	Yes ☐ No ☑ NA ☐

Personal Details

Lifestyle Assessments

Communicating — Interpreter required Yes ☐ No ☐

Any specific needs	What's your normal?	How is it now?	Comments
Speaking	No issues	same	
Reading	No issues		
Writing	No issues		
Vision (please specify if glasses/contact lenses are worn)	Glasses		
Hearing (please specify if hearing aids are worn and if in patient possession)	No issues		

Breathing	What's your normal?	How is it now?	Do you suspect the patient has a respiratory infection? isolate with appropriate precautions and refer to IPC site on Athena
Do you normally have any issues breathing?	COPD		
Equipment / aids - circle all that apply: Inhalers / oxygen-concentrator / cylinder / nebulisers / tracheostomy.			
Do you smoke? Yes ☑ No ☐ If so how many?		Patient wishes nicotine replacement therapy ? Yes ☐ No ☑	

All smokers ***must*** be referred to **"Quit your way"** for discussion about smoking management whilst in hospital (Ask patients permission)

Mobility	What is your normal?	How is it now?	Comments
Bed Transfers	Independent	same	
Chair Transfers	Independent		
Balance	Sometimes unsteady		
Walking Any issues with foot health affecting mobility	Sometime) unsteady		

Oral Care			
Does the patient need assistance carrying their own basic oral care	Yes ☐ No ☑	If yes - Comments	
Does the patient have dentures	Yes ☐ No ☑	Top ☐ Bottom ☐ Partial ☐ With patient ☐	
Is the patient suffering from mouth pain?	Yes ☐ No ☑	**Comments** If you have answered yes commence an oral hygiene care plan.	

Lifestyle Assessments continued

Eating and Drinking		If yes what support is required?
Support required for eating/drinking	Yes ☐ No ☑	
Equipment required to support eating/drinking **Please state what equipment required**	Yes ☐ No ☑	
Is Patient on nutritional supplements / enteral feed at home Yes ☐ No ☑		Type:
Likes..... Dislikes.....	Modified fluid consistency	Modified diet consistency
Swallowing ability impaired Yes ☐ No ☑ (Refer to SLT).	Consent to therapeutic diet (Cultural, ethnic, religious requirements)	Yes ☐ No ☐ Details

Eliminating	What is your normal	How is it now?	
Normal bowel habit. **When did your bowels last move?**	Trouble passing	continent	Do you suspect the patient has infective diarrhoea? Send a sample and isolate patient.
Any problems passing urine?	Trouble passing	continent	

Does the patient have a urinary catheter in situ Yes ☐ No ☑ Date of catheter insertion.....

If yes, apply the Catheter Care Bundle

Long term catheter Yes ☐ No ☑	Date due changed

Complete continence assessment if required ☐
Refer to Adult Continence Assessment Pathway algorithm Referral Date _____

Personal Cleansing and Dressing	What is your normal	How is it now?	Comments
What type of assistance is required by the patient? **(please consider patient preferences)**	Independent	Under	

Urinalysis Results. Please circle where appropriate

NAD ☐	Protein Trace + ++ +++ ++++	Blood Trace + ++ +++	Glucose Trace + ++ +++ ++++	Leucocytes + ++ +++	Nitrates -ve +ve

Only send for culture if suspected;

UTI ☐ Sepsis ☐ MSSU Sent ☐ CSU Sent ☐

Date Last Menstrual Period (if appropriate) Pregnancy Test (if appropriate) +ve ☐ - ve ☐

Glucometer reading result

Person Centred Care:

To promote person-centred care our focus is changing from asking 'What's the matter with you' to asking 'What matters to you'.

We can do this by reliably covering the five 'Must do with me' elements of care with patients and/or their families and carers. This will help to ensure all of the interactions between people using our services and the staff delivering them is person-centred and are characterised by listening, dignity, compassion and respect.

The information required for the following 5 Must Do questions can be captured during your conversations with the patient and their families. There may be no need for you to ask these questions directly but gather that information during the admission process and record below

'MUST DO WITH ME'

1 What matters to you?

Your personal goals and the things that are important to you have been discussed and form the basis of your care or treatment.

2 Who matters to you?

We have asked you about the people that matter most in your life and we have given you the opportunity to involve them in the way that you choose

3 What information do you need?

We have provided you with understandable full information and supported you to make decisions that take account of your personal goals and the things that are important to you.

4 Nothing about me without me.

You will always be given the opportunity to be involved in discussions. All information exchanges and communication between professionals or between different services or supports are transparent and always provide you with the opportunity either to be present or to contribute to the process.

5 Personalised contact

Multi – Disciplinary Discharge Plan

Aim: To ensure a safe and timely discharge planned in partnership with the patient/carer and staff

PATIENTS SHOULD BE CONSIDERED FOR CRITERIA LED DISCHRAGE IF USED APPLY STICKER TO MDT DISCHARGE SUMMARY

Estimated date of discharge.....**Actual date of discharge** .....

Date	Discharge planning should be commenced on the day of admission	Yes	No	Initials
	EDD set and patient and family/carers aware			
	Does the patient require a discharge planning meeting?			
	If yes Record date and outcome on discharge summary.			
	House keys available? ..... Key safe number			
	Own transport arrangements			
	Hospital booked transport Ambulance am pm Ref No: Mode: Ibex chair 1 man ☐ Ibex chair 2 man ☐ Stair climber ☐ Stretcher ☐ Any access issues			
	Referral through PMS Package requested: New homecare ☐ Homecare and rehab ☐ Restart existing package ☐ Handlers single ☐ double ☐ Increase package ☐			
	Homecare confirmed to start on:..... (date & time)			
	IDL complete			
	Equipment / **Date for delivery** / **Delivery confirmed**			

Referrals during patients journey and for discharge			
	Date of referral	Initials	Comments
Dietician			
SALT			
Physio			
OT			
Community Nurse			
Podiatry			
Other			

Day of Discharge checklist	Y	N	NA	Initials
Cannula removed				
Discharge Drugs Available Alert: If patient is diabetic, complete the diabetes discharge checklist				
Patients own meds returned				
Discharge prescription given & explained to patient & family If no, please add to discharge summary				
If DNACPR keep copy in patients notes and send original home. Give to ambulance crew if applicable				
If patient has an ACP send it home with patient.				
Inform family/NOK when patient leaves the ward (including transfer to discharge lounge)				

When patients are transferred, the discharge plan must be handed over to the receiving nurse.

Signature of transferring nurse..... **Signature of receiving nurse**.....

Date.....

MDT Discharge Plan

MDT Discharge Plan

Multi – Disciplinary Discharge Plan

Date	Time	All Care and communication relating to Discharge	Initial

Infection Prevention and Control Clinical Risk Assessment (CRA): Multi-Drug Resistant Organism (MDRO) Admission Screening

Hospital + Ward/Dept: Crosshouse CAU

Admission date: 13/12/20 Time: 09:15

CPE Clinical Risk Assessment (on admission)

Date of Screen:_____Time:_____Print Name:_____(Staff Member)

	(Y/N)
1. **Patient has history of CPE colonisation or infection at any time in the past** (confirm by checking PMS for ALERTS and confirm by asking the patient if there is no record on system)	☑
2. **In the past 12 months** (this will most often require asking the patient):	
• **Patient has been an inpatient outside Scotland**	☑
• **Patient has received holiday dialysis outside Scotland**	☑
• **Patient has been close contact of someone with CPE**	☑

If **YES**, patient should be managed as a CPE positive case + **must** be placed in a single room, and the case discussed with IPCT.

If **YES** to any, patient is at increased risk of CPE colonisation, + **must** be placed in a single room and the case discussed with IPCT.

Discussed with patient and provided information sheet ☐

1. PATIENT PLACEMENT (Single room)

Date_____Signature_____

AND

2. SAMPLES FOR TESTING	(Y/N)
Rectal swab (or stool sample)	☐
AND	
Wound swab, if present	☐
AND	
Invasive device site swab, if present (exc urinary catheter site)	☐
AND	
CSU if catheterised	☐

Date_____Signature_____

MRSA Clinical Risk Assessment

Date of Screen:_____Time:_____Signature:_____

	(Y/N)
1. **Patient has history of MRSA colonisation or infection at any time in the past** (confirm by checking PMS for ALERTS and confirm by asking the patient if there is no record on the system)	☑
2. **Patient admitted from somewhere other than home e.g. another hospital, care home** (confirm by checking admission documentation/PMS)	☑
3. **Patient has wound/ulcer or invasive device present before admission** (may require physical inspection)	☑

If **YES** to any, patient is at increased risk of MRSA colonisation

If **NO** to all **AND** patient is in high impact specialty*

Discussed with patient and provided them with leaflet ☐

1. PATIENT PLACEMENT (refer to MRSA Policy)

Single Room ☐

If placement not possible as per policy, undertake risk assessment and document reasons below:

_____

_____

2. SAMPLES FOR TESTING

Nasal + perineal ☐

AND

Wound/skin break swab, if Present ☐

AND

Invasive device site swab, if present (exc urinary catheter site) ☐

AND

CSU if catheterised ☐

Date_____Signature_____ ☐

**High impact specialties refers to:*
Intensive Care, Orthopaedics, Renal Medicine, Vascular Surgery
Note: If the patient is transferred to UHC or UHA from any NHS A&A Hospital, an additional CRA must be carried out. Additional forms can be obtained from the IPC AthenA site.

January 2019 Version 0.12

If further advice is required contact the Infection Prevention & Control Team (ext 25765) or the on call Consultant Microbiologist (via switchboard)

Risk Assessment

NHS Ayrshire & Arran
Nutritional Screening Malnutrition Universal Screening Tool (MUST)

Food Fluid and Nutrition

Step 1 Measure height and weight to get a BMI score
Step 2 Note percentage unplanned weight loss and score
Step 3 Establish acute disease effect and score
Step 4 Add scored from steps 1,2 and 3 together to obtain overall risk of malnutrition
Step 5 Follow the management guidance appropriate to the risk category and commence the corresponding care plan

Screening Results

Please indicate if measurements are Measured (M), Reported (R) or Estimated (E)

Date	13/12/20				
Time	09:30				
Ward	CAU				
Height (metres) (M) (R) (E)	1.67 m	m	[redacted]		
Current weight (Kg) (M) (R) (E)	68Kg ( )	Kg ( )	Kg ( )	Kg ( )	Kg ( )
BMI	24.9				
Is patient within obese category?	No				
Usual weight (Kg)	Kg	[redacted]			
Signature	SM				
MUST					
Step 1: BMI Score >20 (>30 = Obese) 0 18.5 - 20 1 < 18.5 2	0				
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months. <5% 0 5 - 10% 1 >10% 2	0				
Step 3: Acute Disease Effect Score If patient is acutely ill **and** there has been or is likely to be no nutritional intake for>5 days Score 2 .... Not applicable Score 0.....	0				
Step 4: Overall Risk of Malnutrition Total:	0				
Step 5:	0 = Low Risk	1 = Medium Risk	2 = High Risk		

NHS Ayrshire & Arran

Malnutrition Universal Screening Tool

('MUST') Multidisciplinary Care Plan (FFN)

Patient Problem
Nutritional screening has identified the patient as being Low ☑ ☐ High ☐ Risk of
Patient identified as having other nutritional problems e.g. obesity, chewing certain foods (specify)

Goal

To meet patients nutritional and fluid requirements

Date	Time	Intls	Planned Nursing Interventions/Support	End Date	Intls
			Low Risk Care Plan		
			Assistance required (specify) e.g. helping, prompting, cutting up food, opening packets:-		
			Individual / therapeutic dietary requirements (specify) e.g. likes/dislikes religious/ethical/cultural:-		
			Modified eating equipment (specify) e.g. cutlery.		
			Assist patient to select appropriate meals from menu card.		
13/12/20		SM	Ensure fresh drinking water is offered regularly and available at all times, where clinically appropriate.		
			Consider patients positioning and support oral hygiene, if required.		
			Ensure patients nutritional needs recorded on nutrition board.		
			Monitoring and review care plan **repeat screening weekly** (monthly continuing care).		
13/12/20		SM	This care plan has been discussed and agreed with the patient as appropriate.		
			Medium Risk Care Plan (complete low risk section also)		
			Commence food chart for a minimum of 3 days, Only discontinue if/when dietary intake is adequate.		
			If intake is insufficient, offer patient milk to drink with / and between meals and suitable additional snacks.		
			Record accurate fluid intake / output on fluid balance chart until established that oral intake is adequate. If intake per 24 hours is inadequate consider IV/SC fluids.		
			Provide nutrition information leaflet to carer / relative		
			RED TRAY Yes☐ No☐ **RED JUG** Yes ☐ No ☐		
			High Risk Care Plan (complete low and medium risk section also)		
			Refer to Dietitian, ensuring the MUST score is included.		
			Discontinue food chart only when advised by Dietitian.		
			Administer and monitor enteral feed via NG/PEG route as per local guidelines.		

Care Plan

Care Plan

Date	Time	Intls	Planned Nursing Interventions/Support	End Date	Intls
			This care plan has been discussed and agreed with the patient as appropriate.		

Please record any Therapeutic/Special Diet/Fluids			
Texture/Stage/Type (include diabetic, gluten free etc)	Date commenced	Comments	Date discontinued

Daily Preliminary Pressure Ulcer Risk Assessment (PPURA)

(unless full waterlow required)

Points to consider

- Use within 6 hours of admission to care area
- People who are overweight may not be well nourished
- Please sign after each check

Date 13/12/20 **Time** 09:15		
Mobility		
Patient is fully mobile without equipment/assistance	Yes ☑ No ☐	
Continence		
Patient is fully continent	Yes ☑ No ☐	**If *No*, to any questions undertake Waterlow Assessment and apply SSKIN bundle as indicated**
Nutrition		
Patient appears to be well nourished and able to eat and drink	Yes ☑ No ☐	
Skin		**Assess condition of skin, any wounds/lesions/stomas**
Skin is healthy and intact	Yes ☑ No ☐	
-Dry legs		**If all answers Yes, complete a daily PPURA see page 14**

Use daily if the person is identified to be "not at risk"

Mobility	Person is fully mobile without equipment/assistance
Continence	Person is fully continent
Nutrition	Person appears well nourished and able to eat and drink
Skin	Persons pressure areas are healthy, with no signs of redness, discolouration, including bruising or ulceration

Record your answer in the grid below **Y** – Yes or **N** for No
If the answer is **Yes** to all statements use this chart daily
If the answer is **No** to any statement undertake a pressure ulcer risk assessment and consider any other relevant assessment

Date	Time	Mobility	Continence	Nutrition	Skin Inspected	Is a full pressure ulcer risk assessment required?	Signature

NHS Ayrshire & Arran

Adapted Waterlow Pressure Area – Risk Assessment Chart

More than one score can be used in each section

Complete assessment according to PPURA or if there is a charge in individual's condition and repeat regularly according to local protocol

		Date	13/12/24									
		Time	09:30									
Sex												
Male 1	Female 2		1									
Age												
14 - 49	1											
50 - 64	2											
65 - 74	3		2									
75 - 80	4											
81+	5											
Build/Weight for Height *(BMI=weight in Kg/height in m²)*												
Average - BMI 20-24.9	0											
Above average - BMI 25-29.9	1		0									
Obese - BMI > 30	2											
Below average - BMI < 20	3											
Continence												
Complete/catheterised	0											
Urinary Incontinence	1		0									
Faecal incontinence	2											
Urinary and faecaly incontinent	3											
Skin Type - Visual Risks Area												
Healthy	0											
Tissue paper (thin/fragile)	1											
Dry (appears flaky)	1											
Oedamatous (puffy)	1		1									
Clammy (moist to touch) pyrexia	1											
Discoloured/Bruising/Grade 1	2											
Broken (established ulcer) Grade 2 - 4	3											
Mobility												
Fully mobile	0											
Restless/fidgety	1											
Apathetic (sedated/depressed/reluctant to move)	2		1									
Restricted (restricted by severe pain or disease)	3											
Bedbound (unconscious/unable to change position/traction)												
Chairbound (unable to leave chair without assistance)	5											
Special Risks - Tissue Malnutrition												
Multiple organ failure/terminal cachexia	8											
Single organ failure e.g. cardiac, renal, respiratory	5											
Peripheral vascular disease	5		1									
Anaemia = Hb < 8	2											
Smoking	1											
Special Risks - Neurological Deficit												
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6		0									
Special Risks - Surgery/Trauma												
On table > 2 hours (up to 48 hours post op)	5											
On table for up to 6 hours (up to 48 hours post op) provided 5 the rate of recovery is normal)			0									
Orthopedic/below waist/spinal	8											
Special Risks - Medication												
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*			0									
		Total	6									
		Initials	SM									

<10 Low Risk - Reassess weekly **10+ At Risk - Reassess twice weekly** **15+ High Risk - Reassess on alternate days** **20+ Very High Risk - Assess daily**	• **The Waterlow must be reassessed if the patient's condition changes /deteriorates and the plan of care should be reviewed at that point.** • **For patients who are in long term care, provided their condition is stable after one week of admission the Waterlow can be reassessed weekly/monthly**

NHS Ayrshire & Arran
Pressure Prevention Care Plan (PA)

Patient Problem/Need
Patient has a Waterlow score of ..... and is at risk of developing pressure ulcers
Patient has a pressure ulcer/s grade .....
Goal
Patient's skin will remain intact
To promote healing of ulcer and prevent infection

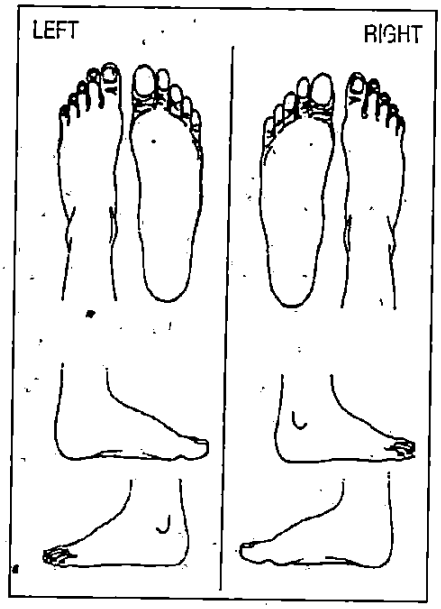
Date	Time	Init	Planned Nursing Interventions	Discontinued Date/Time	Init's
			Calculate and record the Waterlow score on admission and recalculate as the patient's condition changes and on a regular basis		
			Inspect the patient's skin especially over bony prominences on admission and at regular intervals and document findings • Skin condition on admission		
			Select pressure reducing equipment according to patient need • _____ • _____ • _____ • _____		
			When in bed encourage and facilitate position changes using 30 degree tilt (indicate frequency below) • _____		
			The patient should not sit out of bed for longer than 2 hours without being repositioned (for acutely ill patients return to bed for a minimum of 1 hour)		
			Use sliding sheets to prevent shear and friction during movement in bed (Sliding sheets should not be left under the patient)		
			Initiate SSKIN bundle and ensure all elements of this complete		
			When the patient is incontinent refer to the skin care guideline		
			Encourage a healthy, well balanced diet and adequate fluid intake		
			If the patient has a grade 2 or above pressure ulcer a wound assessment chart is required		
			This care plan has been discussed and agreed with the patient as appropriate		

Care Plan

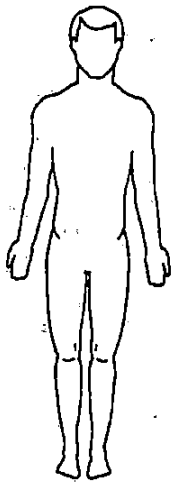
Pressure Ulcer Record

Indicate by circling, numbering and dating all pressure damage on diagrams, then complete box below.

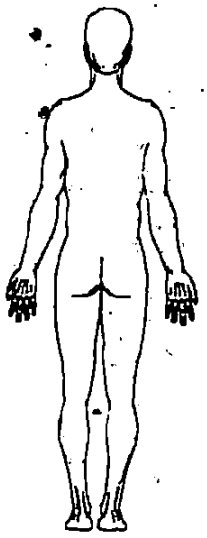
Initiate SSKIN care plan/wound assessment chart



Anterior view



Posterior view



Date	Number of Ulcer	Location of Ulcer	Grade of Ulcer	Datix – Insert reference (grade 2-4 and suspected deep tissue injury	Logged on Safety Cross (Grade 1-4)	Signature	Print Name

Scottish Adapted European Pressure Ulcer Advisory Panel (EDUAP)-Pressure Ulcer Grading Tool 2014

GRADE 1 Intact skin with non blanchable redness, usually over a bony prominence. Darker skin tones may not have visible blanching but the colour may differ from the surrounding skin. The area may be painful, firmer, softer, warmer or cooler than the surrounding tissue.

GRADE 2 Loss of epidermis/dermis presenting as a shallow open ulcer with red/pink wound bed without slough or bruising. May also present as a blister.

GRADE 3 Subcutaneous fat may be visible but bone tendon or muscle is not visible or palpable. Slough may be present but does not obscure the depth of tissue loss. Often includes undermining or tunnelling

GRADE 4 Extensive destruction with exposed or palpable bone, tendon or muscle. Slough may be present but does not obscure the depth of tissue loss. Often includes undermining or tunneling

DEEP TISSUE INJURY – Epidermis is intact but the area appears purple or maroon or is a blood filled blister over a dark wound bed. Over time the skin will degrade and develop into deeper tissue loss.

UNGRADABLE - Full thickness skin loss where the depth of the ulcer is completely obscured by slough/necrosis. Until enough slough or necrotic tissue is removed to expose the base of the wound the true depth cannot be determined. It may be a grade 3 or 4 once debrided

All acquired pressure ulcers graded 2 - 4 and suspected deep tissue damage, must be reported via Datix. Refer to podiatry for at risk feet and foot wounds using " CPR for Feet" Criteria.

Falls for All Bundle

Please complete for all patients on admission within 24 hours

1. 5Q's

a. Has the patient fallen in the last 6 months – including during this admission?	Yes ☐ No ☐
b. Does that patient have cognitive impairment or possible delirium?	Yes ☐ No ☑
c. Does that patient attempt to walk alone although unsteady or unsafe?	Yes ☐ No ☑
d. Does the patient or their relative/s have fear or anxiety, Re falling?	Yes ☐ No ☑
e. Based on your clinical judgment, is this patient at high risk of falling?	Yes ☐ No ☑

If yes to any of the above, the patient is deemed as a vulnerable patient and should be commenced on the more vulnerable falls bundle (recording of this is included in care and comfort rounding or alternatively should be recorded in the patients records).

Initials: SM

Date: 13/12/2020

Time: 09:30

Please repeat if patient has a fall, their condition changes or transferred into your ward or department. Any further stickers can be placed in nursing notes

2. 5Q's

a. Has the patient fallen in the last 6 months – including during this admission?	Yes ☐ No ☐
b. Does that patient have cognitive impairment or possible delirium?	Yes ☐ No ☐
c. Does that patient attempt to walk alone although unsteady or unsafe?	Yes ☐ No ☐
d. Does the patient or their relative/s have fear or anxiety, Re falling?	Yes ☐ No ☐
e. Based on your clinical judgment, is this patient at high risk of falling?	Yes ☐ No ☐

If yes to any of the above, the patient is deemed as a vulnerable patient and should be commenced on the more vulnerable falls bundle (recording of this is included in care and comfort rounding or alternatively should be recorded in the patients records).

Initials:

Date:

Time:

Slips, Trips and Falls – Care Plan (F)

(to be used in conjunction with Falls for All bundle)

Patient Problem/Need
Patient is considered to be at risk of falling
Goal
To promote and maintain patient safety and reduce the risk of falls

Date	Time	Initial	Planned Nursing Interventions	Discontinued Date/Time	Initial
			Orientate patient and family/carers to ward environment on admission and each shift.		
			Ensure buzzer within reach.		
			Explain importance about calling for help when needed.		
			Ensure that bedside table and key belongings are within easy reach.		
			Ensure patient wears appropriate clothing and footwear.		
			Ensure that patient is wearing spectacles if appropriate.		
			Discuss with family/carers how to assist with interventions.		
			Ensure that patient/family receives an explanation of risk and the measures in place to minimise this risk and document outcome.		
			Ensure that standard bed frame is used and left in a low position with brakes on.		
			Select a chair that is the appropriate height and design for the patient (seek guidance from Physio and OT).		
			When in use ensure that chair/commode brakes are secure.		
			Ensure that area is illuminated appropriately at night time.		
			Liaise with medical team re: medication review.		
			Consider referral to Physiotherapy, Occupational Therapy, Social Work.		
			Monitor lying and standing blood pressure.		
			Supervise patient when transferring as per moving and handling risk assessment.		
			Supervise patient when mobilising as per moving and handling risk assessment.		

			Offer toileting facilities as appropriate.		
			Ensure that patient is cared for in an area proximal to toilet facilities, if possible.		
			Encourage family, if present, to sit with patient (as appropriate).		
			Encourage family/carers to report to nursing station when ending their visit.		
			Consider appropriate equipment in liaison with Physio and / or OT.		
			Ensure yellow sticker is inserted into patient's notes after each fall.		
			Patients who may be confused or have had repeated falls where possible should be cared for in an area within the ward that is within easy view of nursing staff.		
			Consider a higher level of supervision of the patient.		
			Consider the use of a low level variable height bed.		
			Above care plan has been discussed and agreed with the patient and / or family / carer.		

NHS Ayrshire and Arran

Bedrails Risk Assessment

Date of Admission ....13/12/20.....

- Each statement must be answered - Circle answer
- Complete Risk Assessment in conjunction with Bedrails Algorithm overleaf
- Refer to Guidelines - Safe Use of Bedrails in In-patient Settings & Falls Prevention
- As accountable RN ensure you have undertaken a visual check of the bedrail prior to use and are satis that there are no obvious faults

Re Assessment Occurs

- Weekly
- When the patient's condition changes (i.e. patient falls/post surgery/change in medication/cognitive state changes)

Ensure clear identification of a change in use of bedrails within documentation and at bed space if consent obtained from patient

Risk Factors	Ward: CKU Date: 13/12/20 Time: 09:15	Ward: Date: Time:	Ward: Date: Time:	Ward: Date: Time:
1. Is the patient at risk of **falling** from bed?	YES / (NO)	YES / NO	YES / NO	YES / NO
2. Is the patient at risk of **intentionally** climbing over the bedrails?	YES / (NO)	YES / NO	YES / NO	YES / NO
3. Is the patient at risk of **unintentionally** falling from the bed/trolley?	YES / (NO)	YES / NO	YES / NO	YES / NO
4. Does the patient **understand** the purpose of the bedrails? Consider communication difficulties and physical/Cognitive condition.	YES / NO / (NA)	YES / NO / NA	YES / NO / NA	YES / NO / NA
5. Does the patient **consent** to the use of bedrails?	YES / NO / (NA)	YES / NO / NA	YES / NO / NA	YES / NO / NA
Has the Bedrails Algorithm been followed?	Yes ☑ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
According to the Bedrails Algorithm are bedrails required / appropriate?	Yes ☐ No ☑	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Bumpers required	Yes ☐ No ☑	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Initials	SM			

If yes, commence a Safe Use of Bedrails Care Plan. If No, state reason why bedrails are not required

Safe Use of Bed Rails – Care Plan (BR)

Patient Problem/Need
The patient is at risk of falling out of bed due to (e.g. cognitive or physical condition)
Goal
To promote and maintain patient safety and reduce the risk of falling out of bed

Date	Time	Initial	Planned Nursing Interventions	Discontinued Date/Time	Initial
			Ensure assessment is made on admission, when patient's condition changes, and weekly as a minimum.		
			Ensure rationale for decision made re; the use of bedrails is clearly documented.		
			Consider psychological effects of bedrail usage on patient and where appropriate ensure the patient's consent to their use.		
			Ensure risk of entrapment is minimised by careful positioning of patient prior to operating bedrails.		
			If detachable bedrails used, ensure the gap between the top end bedrail and head of bed is less than 6cm or more than 25cm.		
			If detachable bedrails used, ensure the gap between the bottom end of bedrail and foot of bed is more than 25cm.		
			Continually monitor risk of patient climbing over the top of bedrails and assess the use of bedrails as necessary.		
			Discuss with the patient, the need to share information with other nurses and health care workers re; the use of bedrails, and document within the nursing documentation whether the patient consents to display information at the bed space.		
			Provide Falls/Use of Bedrails information leaflet to patient. Where the patient is incapacitated, ensure that relative/carer is given a leaflet and information about the assessment for bedrails is provided.		
			Ensure all actions, including discussions with relative/ carers are documented.		
			Refer to the Safe Use of Bedrails in Adult In-Patient Settings Guideline for further guidance on the management of bedrails.		
			Re-assess the need for bedrail use at least weekly or as the patient's condition indicates and document on the risk assessment chart.		
			This care plan has been discussed and agreed with the patient as appropriate.		

Moving and Handling

Patient Risk Assessment

All Patients:

Sliding aids **must** be used bed to trolley/bed unless the patient transfers independently A hoist **must** be used if assistance is required from the floor
A hoist **must** be used for bathing unless independently mobile
Hoists are for lifting patients and must not be used for transport between rooms

Special Alerts: **Date:**						
Overweight / Obese (BMI definition)						
Very tall (>185cm in height)						
Restricted use of limbs						
Poor standing ability						
Sedation or lethargy						
Irrational behaviour / confusion						
Unable to co-operate						
Acute pain						

Assessment of Risk:

Low Risk: Independently mobile / supervision only required. Aids required should be specified in care plan

Moderate Risk: Requires physical assistance from one or more handlers. Is able to stand or partially bear weight and has no more than one special alert.

High Risk: (a) Is unable to bear weight and requires assistance.
(b) 2 or more special alerts present and requires assistance.

Aids, equipment and a minimum of 2 handlers recommended to move a patient.

Date:						
LOW RISK						
MODERATE RISK						
HIGH RISK						
Assessor's Initials						

If a hoist or standing aid is required please specify:

Sling type:		**Size:**		**Manufacturer:**	

Additional Comments:

Moving and Handling Care Plan (MH)

Date:						
1. Moving in bed: a) Independent b) Handlers and sliding sheets required to move in bed - specify number of handlers in grid c) Specify any additional equipment required in grid	a) b) c)					
2. Sitting to Standing: a) Independent b) Requires assistance from sit/stand to sit? Specify number of handlers in grid c) Also requires aids. Specify equipment in grid	a) b) c)					
4. Transfers: (chair / wheelchair / commode / toilet / bed) a) Independent or with minimal supervision b) Assistance required from handlers specify number of handlers in grid. c) Equipment required - specify equipment in grid	a) b) c)					
4. Adjusting Clothing a) Independent or minimal supervision b) Can use support/grab rails while assistance is given with clothing c) Requires support from Handler(s) while another assists with clothing d) Requires equipment, specify equipment in grid	a) b) c) d)					
5. Repositioning in chair / wheelchair: a) Independent or minimal supervision b) Assistance from handler(s), specify number in grid c) Specify other aids or equipment required in grid	a) b) c)					
6. Mobilising:	Documented in Mobility Care Plan					
Assessors initials						

If it is decided to stand, transfer or mobilise a patient requiring assistance of more than 2 handlers, without equipment, a detailed assessment outlining the decision making process must be documented in the mobility careplan.

Mobilising – Care Plan (M)

Patient Problem/Need
Patient has restricted mobility/mobility is deteriorating due to.....
Goal
To optimise ability to mobilise safely and maintain independence as much as possible

Date	Time	Initial	Planned Nursing Interventions	Discontinued Date/Time	Initi
			Refer to moving and handling risk assessment tool and plan care accordingly.		
			Mobilise/transfer with assistance of one/two handlers.		
			Mobilise/transfer with supervision.		
			Mobilising with appropriate handling equipment and/or aids, please state:-		
			• Walking stick one/two		
			• Tripod/quad		
			• Zimmer frame/rolator		
			• Wheel chair		
			• Hoist aid (specify equipment used)		
			• Other (please specify)		
			Refer to physiotherapist and action specialist requirements.		
			This care plan has been discussed and agreed with the patient and/or carer/relative as appropriate.		

Care Plans and Monitoring Charts Codes for Evaluations

Code	Care Plan / Chart / Ref	Code	Care Plan / Chart / Communication
A	Admitted as emergency		
AHP	Allied health professional (Please specify)		
B	Breathing		
BR	Bed Rails		
BT	Blood Transfusion		
CP	Communication (With patients)		
CF	Communication (With family)		
CC	CAUTI		
CI	Cognitive Impairment		
COI	Control of Infection		
D	Cleansing and Dressing		
E	Elimination		
EM	Emotional wellbeing / anxiety		
F	Falls		
FFN	Food Fluid Nutrition / MUST		
I	Investigations		
M	Mobilising		
MDT	MDT Communication		
MH	Moving and Handling		
N	NEWS		
O	Oral Hygiene		
P	Pain Management		
PA	Pressure Area Care		
Pre Op	Pre operative		
Post Op	Post Operative		
PVC	PVC Chart		
T	TIME Bundle for delirium		
V	Violence and Aggression / Challenging Behaviour		
W	Wound Management		
WR	Ward Round		

Ward Care Notes

Date & Time	Initial Medical/ANP presentation and management plan	Initi
13/12/20 11:00	Imp: DT Plan: GMAWS Mg added → 0.77 Pabrinex Monitor for further signs bleeding - VTE prophylaxis not prescribed	Sr
13/12/20	Imp: - AIC WLD - ? malena Plan: pabrinex - PRN GMAWS - chase for GI bleed - AIC liaison	QN

Ward ...CAU.....

Date & Time	Care Plan Code	Record of all care. Including Ward round / MDT and Relative communication	Initials
13/12/20		Patient admitted from ED.	
11:55	N	News 1 SpO_2 at 95%	
	FFN	Patient seems settled had a cup of	
	P	coffee. No complaint of pain	
		Patient administred 10mg diazapam	
		as charted on GMAWS.	SM
15:00	N	News 1 as sats maintainig at 95%	SM
13/12/20	P-	nil complaints	
1840	S-	Settled at present	
13.12.2020		- NEWS - SCORE 0	
2330		- PATIENT RELAXED IN BEDSPACE	
		- NOT SLEEPING ON GMAWS	
		- ALL MEDICATION TAKEN AS CHARTED	
		- NO NEW COMPLAINTS	
		- HOT DRINK AND SANDWICH PROVIDED	RLL
14.12.2020		patient appears settled	
0200		and sleeping	
		- not requiring diazepam PRN	RLL
14.12.2020		- patient settled in bedspace	
0630		- NEWS - Stable	
0700		- patient went outside for cigarette, no new issues	RLL
14[00]		Alcohol liason referral done.	
		Alcohol liason phoned will visit	
		patient on thursday 17/12.	
	N	News score 1 HR 97	

Ward Care Notes

Ward .....

Ward Care Notes

Date & Time	Care Plan Code	Record of **all** care. Including Ward round / MDT and Relative communication	Init
		Scoring on GMAWS-	
		Mobile + independant.	
		Tolerating diet + fluids	
		Passing urine spontaniously via toilet	
14/12/20	WR	Reviewed by Sst Hughes:	
		plan-continue pabrinex / GMAWS	
		- repeat bloods.	
14/12/20 1850	E	independent with continence care, passing via toilet.	
	FFFV	tollerating diet and fluids well.	
	M	independently mobile.	
	N	NEWS-0 as charted.	
	P	no complaints of pain at present. Medication taken as prescribed and charted via JAC system.	
	PVC	~~IV antibiotics given throughout day.~~ is.	
	Em	appears settled at present.	SG
14-12-20 1950		scoring on GMAWS at present.	LS.
14.12.2020 2200		- NEWS-0 - all meds given as charted - diazepam given as charted on GMAWS. - patient given coffee. - patient went outside for cigarette - no new issues	

Ward .....

Date & Time	Care Plan Code	Record of **all** care. Including Ward round / MDT and Relative communication	Initials
		Reported	
16.12.2020 0010		-patient settled in bay appears to be watching something on his phone no new issues voiced	
16.12.2020 03[00]		-patient appears to be settled and sleeping no new concerns voiced	
16.12.2020 07[00]		-NEWS-0 - NOT scoring on CIWA's. - Patient settled on beside pan	
1030		Patient remains settled in bed space. Not scoring on CIWA's at present. Tolerating diet + fluids Medications given as charted No c/o pain or nausea. Nil concerns. ———	CB
1400		Patient remains settled given 10mg of diazepam as per CIWA's chart. NEWS-1 (HRT 101) In and out of ward for cigarettes. Nil concerns. ———	CB.
		Reviewed by medics (P) Pabonnex/CIWA's Bloods Monitor Bloods	CB.
1810		Patient remains settled in bay area. NEWS-0	

Ward .....

Ward Care Notes

Date & Time	Care Plan Code	Record of **all** care. Including Ward round / MDT and Relative communication	In
		AMAWS-0	
		Tolerating diet + fluids,	
		Nil concerns	
16/12/2020		NEWS of 1	A
0150		Medication given as per JAE. IV Paracetamol given	
		Not scoring on AMAWS. Cond swabs obtained	
		Independently mobile to toilet when required	
		No concerns as at time of report	
		Generally ~~slept~~ settled well with barely any sleep	
1420	N	NEWS as charted	
	FFN	Good dietary intake	
	I	Not scoring on AMAWS	
	M	In and out of unit for cigarettes	
	WR	Reviewed by Dr Smith	
		Plan: rpt bloods today ✓	
		◦ stool chart	
		◦ alc liason ✓	
		◦ if no malena, bloods ↩ ? (H) later for OP OGD	
1930	CP	Patient discharged home. Arranged taxi for transport home.	

National Early Warning Score

GALLOWAY Stephen
28 REDBURN PLACE, IRVINE
KA12 9BH
DOB: 14/06/1965

	Date	Ward
Admitted		
Transferred		
Transferred		

Special Instructions - to be completed by Medical Team

A total NEWS score of _____ due to _____ or individual parameter range of _____ is acceptable for this patient because _____

Please escalate if _____

Print _____ Sign _____ Designation _____

Date _____ Time _____ *(only valid if signed and*

A total NEWS score of _____ due to _____ or individual parameter range of _____ is acceptable for this patient because _____

Please escalate if _____

Print _____ Sign _____ Designation _____

Date _____ Time _____ *(only valid if signed and a*

See NEWS Actions Reference Tool for local escalation policy

News score	Frequency of monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every observations
Aggregate 1-4	Minimum 4 hourly	• Inform trained nurse • Trained Nurse assessment - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care a as appropriate
Aggregate 5 or more *or* any single red score	Increase frequency to a minimum of 1 hourly	• Trained Nurse assessment • Inform medical team caring for the patient and response • Urgent assessment by a medical / surgical / nurs team with core competencies to assess acutely il patients • Consider level of monitoring required in relation clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately • Inform medical team caring for the patient - this be at least senior medical staff level. If unable to promptly, escalate to consultant or Emergency R Team. • Emergency assessment by a clinical team with co competencies in the assessment of critically ill pat • Consider referral to high dependency or ITU.

Pain Score

Ask the patient to rate his/her pain by choosing a number between 0 and 10.

Use the diagram below to assist the patient if required. If the patient is unable to communicate, refer to an alternative pain scoring tool eg. Abbey, and use your clinical skills to determine level of pain severity.

0	1	2	3	4	5	6	7	8	9	10	A
No Pain	Mild Pain			Moderate Pain			Severe Pain				Asleep

Nausea and Vomiting	
0	None
1	Mild (Not distressing - no retching/vomiting)
2	Moderate (Troublesome - occasional retching/vomiting)
3	Severe (Distressing - frequent retching/vomiting)

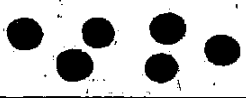
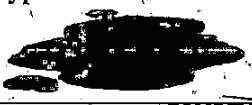
NEWS - NHS Early Warning Score

Physiological Parameter	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92 - 93	94-95	>96			
Any Supplementary Oxygen		Yes		No			
Temperature	≤35.0		35.1-36.0	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V,P or U

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

Notes

Bristol Stool Chart

Type 1 	Separate hard lumps, like nuts (hard to pass)
Type 2	Sausage-shaped but lumpy
Type 3	Like a sausage but with cracks on its surface
Type 4	Like a sausage or snake, smooth and soft
Type 5	Soft blobs with clear cut edges (passed easily)
Type 6	Fluffy pieces, a mushy stool
Type 7 	Watery, no solid pieces ENTIRELY LIQUID

NHS
Ayrshire
& Arran

SMOKE FREE GROUNDS POLICY

DISCLAIMER GUIDANCE

Please note as part of the nursing admission documentation all patients who are smokers should be referred to the Quit Your Way smoking cessation service via Trakcare

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158
Date of Birth .....

Smoke Free Grounds Policy

Patient Disclaimer

Hospital:	
Ward/Station/Dept:	
Patient Name:	J GALLOWAY

I _____(print name) have been provided with information regarding the management of smoking in hospital in compliance with the NHS Ayrshire & Arran Smoke Free Grounds Policy and I understand that I am not permitted to smoke anywhere on NHS A&A grounds.

I have read and understood this information. I have been advised against leaving the ward to smoke. I understand that there are risks associated with leaving the ward/department. In particular I understand that my decision will affect the medical attention I receive and that NHS Ayrshire & Arran cannot provide medical care and attention to me whilst I am absent from the ward/department. I therefore accept that the staff cannot be responsible for my care whilst I am absent from the ward and hospital grounds.

Patient Signature:	[signature]	Witness Signature:	[signature]
Date:	13/12/20	Date:	13/12/20
Time:	11:45	Time:	11:45

PLEASE FILE THIS FORM IN NURSING NOTES ENSURING CIRCUMSTANCES ARE FULLY DOCUMENTED

| | | |

CARE & COMFORT ROUND incorporating Falls and SSKIN bundles

Documentation codes: √ when care/action is give/completed **Re** – refused **A** – asleep **N/A** – not applicable
V – variance – record on evaluation sheet on page 2

GALLOWAY Stephen
28 REDBURN PLACE, IRVINE
KA12 9BH
DOB: 14/06/1965

NH
Ayrsh
& Arr

It is not necessary to write in every box every time a care and comfort round is undertaken, only complete as required using the codes above

1. CARE & COMFORT ROUND

Date	13/12	13/12	13/12	13/12									14/12	14/12	14/12	14/12	14/12	14/12	14/12	15/12	15/12	15/12	15/12	
Time – using 24-hour clock (record actual time completed)	10 00	14 00	18 00	22 00	02 00	06 00	10 00	14 05	18 10	22 50	02 10	06 05	10 00	14 00	18 00	22 00	02 00	06 00	10 00	14 15	18 00	22 00	02 00	06 00
Please state frequency of bundle completion: i.e.1hrly (2hrly) 4hrly 6hrly 8hrly 12hrly	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Is this patient more confused or has their behaviour changed since you last spoke to them? (*if yes, carry out 4AT if no other clinical reason*)	N	N	N	N	N	N	N	N	A	A	A	A	N	N	N	N	N	N	N	A	A	A	N	N
Orientate to time & place as appropriate and encourage opportunity to express needs	✓	✓	S	S	✓	✓	✓	✓					✓	✓	✓	✓	✓	✓	✓				✓	✓
Assess pain & ensure patient is comfortable (If Pain present - Commence pain chart and action)	✓	✓	C	C	✓	✓	✓	✓					✓	✓	✓	✓	✓	✓	✓				✓	✓
Encourage/support oral diet & fluids where appropriate	✓	✓	E	E	✓	✓	✓	✓					✓	✓	✓	✓	✓	✓	✓				✓	✓
Offer assistance to visit toilet/any other continence needs		I	E	E	I	I							I	I	I	I	I	I	I				I	I
Encourage/assist patient to mobilise if safe and appropriate *(Even if it is just around the room)*		I	P	P	I	I							I	I	I	I	I	I	I				I	I
Bowels have moved – Record Bristol Stool score NOTE:If ≥3 consecutive episodes of BS score ≥5 commence stool chart																								
Assist with personal hygiene as required: **BB**-bed bath **IB**-immersion bath **BW**-basin wash **SH**-shower													SH											
Offer assistance with oral care																					A	A	A	
Provide assurance that you will return in a timescale	✓	✓	✓	✓	✓	✓	✓	✓					✓	✓	✓	✓	✓	✓	✓				✓	

ONLY to be completed if the patient triggers on the falls for all bundle (see in patient profile) Please record N/A if any aspects of the falls bundle is not relevant to the patient (i.e. patient does not require walking aid, footwear or glasses or unable to use their call bell) ALL aspects of the bundle must be completed at every bundle completion

2. FALLS BUNDLES

Please state frequency of bundle completion i.e. 1hrly (2hrly) 4hrly 6hrly 8hrly 12hrly	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Environment is clear of clutter & well lit																								
Call buzzer in reach & working																								
Appropriate footwear available & in use																								
Glasses & hearing aid worn if they require available & in use																								

Personal Details

Prefers to be known as:	Age:
Stevie	53
Receiving Consultant:	Allocated Consultant:
From where: GPreferral	Accompanied by: BIBA
Emergency ☑ Elective ☐	Patients telephone number:
	Patients mobile number: 07468337186

H CHI: 1406650854
C Galloway, Stephen
S 28 Redburn Place
F Irvine
A KA12 9BH
.. 14/06/1965
L Dr TG Miller
MRN: XHI468158

GP Name:
GP Address: Frew Terrace

Reason for Admission

?Chest infection
Cough, SOB

Patients Account of Reason for Admission

Has tag - has let police (Cpn.

Next of Kin/First contact/Significant other

Name: ~~Sophie Galloway~~
Address:

Relationship to patient: ~~Daughter~~
Contact No(s) Home:
Mobile:
Aware of admission Yes ☐ No ☐
Contact overnight Yes ☐ No ☐

Consent to share information with significant other listed: Yes ☐ No ☐

Second contact/significant other

Name: Hugh Galloway
Address:

Relationship to patient: Brother
Contact No(s) Home:
Mobile:
Aware of admission Yes ☐ No ☐
Contact overnight Yes ☐ No ☐

Specific Alerts

Previous known MRSA Yes ☐ No ☑
Ensure risk assessment completed

Clostridium Difficile Yes ☐ No ☑
ESBL Yes ☐ No ☑
Other infectious conditions? Yes ☐ No ☑
Specify:

Specific Alerts

Drug Allergies:

Other allergies (food, latex, etc)

None known ☑

Observation on admission	+ ++ +++ ++++	+ ++ +++	+ ++ +++ ++++	+ ++ +++	-ve +ve
Urinalysis NAD ☐	Protein Trace	Blood Trace	Glucose Trace	Leucocytes Trace	Nitrates
MSSU collected?		Yes ☐	No ☐	Date.....	

Glucometer Reading: Yes ☐ No ☑ Result:.....	Date Last Menstrual Period (if appropriate)	Pregnancy Test (if appropriate) +ve ☐ -ve ☐

Pain Score	low						severe				
	0	1	2	3	4	5	6	(7)	8	9	10

For patients with cognitive impairment please refer to Abbey pain scale

Abbreviations

This abbreviation list has been approved for use by NHS Ayrshire & Arran

ANP	Advanced Nurse Practitioner	ICES	Intermediate Care and Enablement Services
ABG	Arterial Blood Gas	ICU	Intensive Care Unit
BM	Blood Glucose Monitoring	IM	Intramuscular
BMI	Body Mass Index	INR	International Normalised Ratio
BO	Bowels Open	IV	Intravenous
BP	Blood Pressure	LFTs	Liver Function Tests
CABG	Coronary Artery Bypass Graft	L+S BP	Lying and Standing Blood Pressure
CAU	Combined Assessment Unit	MAR	Medication Administration Record
CCU	Coronary Care Unit	MEWS	Modified Early Warning Score
CDI	Clostridium Difficile Infection	MHC	Medical High Care
CDU	Clinical Decisions Unit	MI	Myocardial Infarction
CHI	Community Health Index	MRI	Magnetic Resonance Imaging
CKD	Chronic Kidney Disease	MRSA	Methicillin Resistant Staphylococcus Aureus
CLD	Criteria Led Discharge	MSSU	Mid Stream Specimen of Urine
CLDT	Community Learning Disability Team	MUST	Malnutrition Universal Screening Tool
COPD	Chronic Obstructive Pulmonary Disease	NAD	No Abnormalities Detected
CPR	Cardio Pulmonary Resuscitation	NBM	Nil By Mouth
CRP	C - Reactive Protein	NG	Nasogastric
CSU	Catheter Specimen of Urine	NOF	Neck of Femur
CSW	Clinical Support Worker	O2	Oxygen
CT	Computerised Tomography	OT	Occupational Therapist
CVC	Central Venous Catheter	PEG	Percutaneous Endoscopic Gastrostomy
DOB	Date of Birth	PICC	Peripherally Inserted Central Catheter
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation	PMH	Past Medical History
ECG	Electrocardiogram	PN	Parental Nutrition
ED	Emergency Department	PVC	Peripheral Vascular Catheter
EDD	Estimated Date of Discharge	SP02	Saturation of Peripheral Oxygen
ERCP	Endoscopic Retrograde Cholangiopancreatography	SBAR	Situation Background Assessment Recommendations
ERT	Emergency Response Team	SC	Subcutaneous
ESBL	Extended Spectrum Beta Lactamase	SLT	Speech and Language Therapy
ESR	Erythrocyte Sedementation Ratio	TFTs	Thyroid Function Tests
FBC	Full Blood Count	USS	Ultra Sound Scan
GP	General Practitioner	U&Es	Urea and Electrolytes
H@N	Hospital at Night	UTI	Urinary Tract Infection
HAI	Healthcare Associated Infection	WCC	White Cell Count
HDU	High Dependency Unit	WZF	Wheeled Zimmer Frame

Personal Details

Clinical Team Signatures

All staff completing the documentation **must** complete this section

CHI: 1406650854
H GNo:loway, Stephen
C 2o·Redburn Place
S Irvine
F KA12 9BH
A 14/06/1965
Dr TG Miller
MRN: XHI468158
Date of birth:

Name (BLOCK CAPS)	Profession	Ward/ Page No	Signature	Initials
J Grant	SN	CNU		JG
SBOYCE	SN	DSU		SB
LYNDSEY MCFADYEN	SIN	DSU	LMcF	LM
TRACY FLITCROFT	SN	DSU	T Flitcroft	TF
JENNY MILLAR	SN	3D	JMillar	JM
Norma Smith	DSN	3D	nsmith	NS

Colour codes for sections within

Risk Assessment	Lifestyle Assessment
Personal Details	Patient/Family Communication
Care Plans	MDT Discharge Plan
Ward Round Instructions	Nursing Care Evaluation
MDT Communication	

SCN - Senior Charge Nurse
STN - Student Nurse
DCN - Deputy Charge Nurse
HCA - Health Care Assistant
RN - Registered Nurse
HCSW - Health Care Support Worker
AHP - Allied Health Professional

Our purpose

0800 840 0783

Working together to achieve the healthiest life possible for everyone in Ayrshire and Arran

NHS Ayrshire & Arran

Name: _____

CHI Number:

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
K__ 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

PATIENT PROFILE

Please complete below when patient is admitted or transferred to your clinical area

	Admission		Transfer 1		Transfer 2		Transfer 3	
Hospital	Crosshouse		Yhoyes					
Ward	CAU		DSU					
Consultant	Russell		?					
Date / Time	21.1.19	1715	21.1.19	2230				
Relative Informed	(Yes)	No	Yes	(No)	Yes	No	Yes	No
ID Band in situ	(Yes)	No	(Yes)	No	Yes	No	Yes	No
Completed By - Signature								

The Patient Profile can be used for patients with ongoing regular treatment i.e. for a course of therapy or weekly blood transfusion, however if there is a gap of more than 6 weeks since last attendance repeat lifestyle assessment (p15).

If the patient is readmitted into UHC or UHA an additional MRSA/CRA (p20) must be completed. Additional forms can be obtained from the infection control AthenA site.

This profile can also be used for readmission within 3 days.
Please remember to review earlier risk assessments.

Property handed over for safe keeping

PLACE VALUABLES STICKER HERE

Our values

NHS
Ayrshire
& Arran

PRESCRIBING GUIDANCE

DOSE EQUIVALENCE
APPROXIMATE ORAL BENZODIAZEPINE EQUIVALENCE: 10mg diazepam = 1mg lorazepam
ORAL to IM / IV BENZODIAZEPINE DOSE EQUIVALENCE: IM / IV benzodiazepine dose equivalent is half the oral dose.
Example: patient requires diazepam 20mg four times per day orally. Equivalent dose of IM / IV diazepam would be 10mg four times per day. Equivalent dose of oral lorazepam would be 2mg four times per day. Equivalent dose of IM/IV lorazepam would be 1mg four times per day.

EXCEPTIONAL PATIENT GROUPS:

- Actual or suspected head injury
- Hepatic impairment (patients with elevated Bilirubin or Prothrombin Time who are at risk of benzodiazepine accumulation)
- Other co-morbidities where the patient is at risk of over-sedation on respiratory depression e.g Respiratory or cerebrovascular disease, reduced Glasgow Coma Scale

Consider the use of oral Lorazepam in these exceptional patient groups in a symptom triggered fashion: dose should be based on the patient's GMAWS score.

ELDERLY PATIENTS (>65 years) +/OR PATIENTS WITH CrCl <20 ml/min:

In general *half the dose of benzodiazepines* is usually recommended (the need for this is dependent on overall fitness, co-morbidity and degree of frailty). To minimise adverse effects associated with benzodiazepines (e.g. over sedation, confusion and ataxia) it is important to bear in mind the *start low and go-slow* rule in these patient groups (start with lower doses, monitor frequently and increase if necessary as symptoms suggest).

PATIENTS UNABLE TO TOLERATE ORAL MEDICATION

Patients unable to tolerate oral medication may receive intravenous therapy as an alternative at **50% of the oral dose** in the first instance, and response assessed. Please consider benzodiazepine dose equivalences (see above).

MONITORING

All patients should be closely observed for signs of over-sedation with regular observations. Exceptional Patient Groups (see above), patients with Severe Withdrawal and patients requiring Intravenous or Intramuscular Sedation require close monitoring (NEWS). Please refer to the NHS Ayrshire & Arran Clinical Guideline G078 for further information on the care of patients requiring a Higher Level of Supervision in Acute Hospital Settings.

PABRINEX ADMINISTRATION

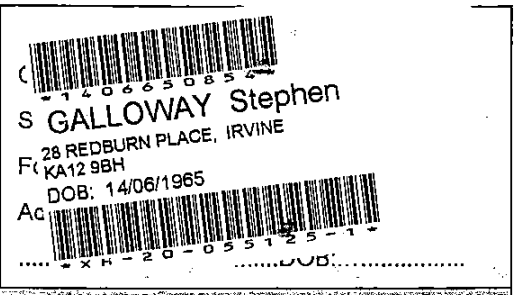
Please refer to ADTC 92 In-patient Guideline for treatment of Thiamine Deficiency in patients with Chronic Alcohol misuse using Pabrinex® Injection. Patients at risk or with suspected of Wernicke's Encephalopathy should be prescribed high dose parenteral Pabrinex® 2 pairs three times daily intravenously for 3-5 days or until clinical improvement ceases.

DISCHARGE PLANNING

Patients should not be routinely discharged until detox process is complete.

NHS
Ayrshire & Arran

Ayrshire Assessment and Management of Alcohol Withdrawal Syndrome (AAMAWS)



STEP 1: DETERMINE ALCOHOL HISTORY (to be completed by the prescriber)

Estimated Weekly Alcohol Units: _____ (Daily Units x 7 days)
excessive weekly consumption (♂& ♀ >14 units/week)
Estimated day/time of last drink: _____ (if > 5 days, re-consider alcohol withdrawal status)
Presents with (or previous history) Alcohol Related Seizure **Yes** ☐ **No** ☐
Presents with (or previous history) Delirium Tremens **Yes** ☐ **No** ☐

Number of Units = ABV (%) x Volume (litres) e.g.

A bottle of wine (750mls) which is 12% ABV = 12 x 0.75 = 9 Units
A glass of wine (200mls) which is 12% ABV = 12 x 0.2 = 2.4 Units

ALCOHOL SCREENING TOOL *("Audit PC")*

	SCORE					
	0	**1**	**2**	**3**	**4**	**Total**
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times a week	4 or more times a week	
2. How many **units of alcohol** do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often during the last year have you found that you were not able to stop drinking once you had started	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you failed to do what was normally expected of you because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes but not in the past year		Yes during the past year	
TOTAL SCORE:						

0-5:Responsible drinking pattern **6-10:Hazardous drinking pattern**
11-14:Harmful drinking pattern **15-20:Dependent drinking pattern**
If Audit PC score indicates that the individual is drinking at harmful / hazardous / dependent levels referral to be made to Alcohol liaison.

STEP 2: DETERMINE TREATMENT OPTION FOR THE MANAGEMENT OF ALCOHOL WITHDRAWAL SYNDROME (to be completed by the prescriber)

RISK OF SEVERE ALCOHOL WITHDRAWAL

Any 2 of the following:
- Presents with or has had previous withdrawal seizures ☐
- Previous episode of Delirium Tremens ☐
- Clinically has alcohol dependence / scoring 15 or above on Alcohol ScreeningTool *Audit PC* (see step 1 above) ☐
- High initial symptom score (GMAWS > 8) ☐
  (Do not use scoring tool if patient intoxicated or < 8 hours since last drink)

YES → FIXED DOSE TREATMENT **(AAMAWS)** **PLUS** SYMPTOM TRIGGERED TREATMENT **(GMAWS – standard or reduced dose diazepam or lorazepam)**

NO → SYMPTOM TRIGGERED TREATMENT **(GMAWS – standard or reduced dose diazepam or lorazepam)**

SELECT TREATMENT OPTION:

NO TREATMENT ☐ **GMAWS only** ☐ **GMAWS PLUS FIXED DOSE (AAMAWS)** ☐

Treatment must be prescribed on HEPMA and GMAWS prescription chart overleaf
NOTE! Fixed dose & symptom triggered dosing must be no less than 1 hour apart

Does the patient require a PVC? Consider DRIFT!

Diagnostics	Resus	IV meds	Fluids	Transfusion
Does the patient require a PVC for diagnostic purposes eg CT Scan?	Is the patient at risk of a cardiac or respiratory arrest that may require resuscitation?	Does the patient require IV medication? (Can this be switched to the oral route?)	Does the patient require IV Fluids? (Are they now able to receive sufficient fluids by the oral route?)	Does the patient require transfusion of any blood products?

Patient meets 1 or more requirements of DRIFT

Yes (PVC required)	No (PVC not required)
• Complete Insertion sticker • Maintain PVC daily	• Encourage diet and fluids where appropriate

PVC Insertion Bundle

PVC Insertion Bundle

Name Stephen Galloway CHI 1406650854

Date 14-12-20 Time 1510

Insertion Site L Hand Colour PINK

Inserted by Dressing Designation 3

1st attempt ☒ 2nd attempt ☐ 3rd attempt ☐

Insertion Criteria (circle those that apply)

Diagnostics Resus (IV meds) (Fluids) Transfusion

Clean Field ☒ Hand Hygiene ☒

Skin asepsis ☒ Non touch technique ☒

Flushed as Per Policy

Maintenance Bundle (please circle all that applies eg (D) R I F T)

Hand hygiene must be performed before & after all procedures. Prior to access, the hub must be scrubbed with 2% CHG & 70% IPA (Clinell wipe (Green))

Day	Date	PVC has been insitu < 72 hours	Patient requires a PVC because: (see above)	The PVC dressing appears:	The PVC site appears:	The PVC was:	Initials	Ward
1	...../...../.....	(< 72hours)	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		
2	...../...../.....	(< 72hours)	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		
3	...../...../.....	(< 72hours)	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		
4	...../...../.....	Document risk assess (> 72hours)	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		
5	...../...../.....	Document risk assess (> 72hours)	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		

NB If the PVC site is inflamed, please remove and obtain a) (charcoal swab)

Version 1

Does the patient require a PVC? Consid DRIFT!

Diagnostics	Resus	IV meds	Fluids	Transfusion
Does the patient require a PVC for diagnostic purposes eg CT Scan?	Is the patient at risk of a cardiac or respiratory arrest that may require resuscitation?	Does the patient require IV medication? (Can this be switched to the oral route?)	Does the patient require IV Fluids? (Are they now able to receive sufficient fluids by the oral route?)	Does the patient require transfusion of any blood products?
Patient meets 1 or more requirements of DRIFT				
Yes (PVC required)			No (PVC not required)	
• Complete Insertion sticker • Maintain PVC daily			• Encourage diet and fluids where appropriate	

PVC Insertion Bundle

Name Stephen Galloway CHI 1406650854

Date 15/12/20 Time 10:05

Insertion Site R arm Colour Pink

Inserted by T. Davis Grade NA

1st attempt ☑ 2nd attempt ☐ 3rd attempt ☐

Insertion Criteria (circle those that apply)

Diagnostics Resus (IV meds) Fluids Transfusion

Clean Field ☑ Hand Hygiene ☑

Skin asepsis ☑ Non touch technique ☐

Maintenance Bundle (please circle all that applies eg (D) R I F T)

Hand hygiene must be performed before & after all procedures. Prior to access, the hub must be scrubbed with 2% CHG & 70% IPA (Clinell wipe (Green))

Day	Date	PVC has been insitu < 72 hours	Patient requires a PVC because: (see above)	The PVC dressing appears:	The PVC site appears:	The PVC was:	Initials	Ward
1	...../...../.....	(< 72hours)	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		
2	...../...../.....	(< 72hours)	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		
3	...../...../.....	(< 72hours)	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		
4	...../...../.....	Document risk assess (>72hours)	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		
5	...../...../.....	Document risk assess (>72hours)	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		

NB If the PVC site is inflamed, please remove and obtain a swab (charcoal swab)

Chair & bed consistently at best height for individual, to enable safe transfers	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓												
Bed rails in use? Please state 1 or 2 or NA	2	2	2	2	NA	NA	NA	NA	2																

ONLY to be completed if required following PPURA Assessment- Please record N/A if any aspects of the SSKIN bundle is not relevant to the patient (i.e. patient does not require a cushion or heel protectors) ALL aspects of the bundle must be completed at every bundle completion

3. SSKIN BUNDLE

Please state frequency of bundle completion i.e. 1 hrly 2hrly 4hrly 6hrly 8hrly 12hrly																									
Time – using 24-hour clock (record actual time completed)																									
Surface – tick when checked (tick if equipment is in use and working-remember mattress alone will not protect heels)																									
Mattress appropriate (Please state mattress type)	Y = Appropriate																								
	O = Ordered																								
Cushion/heel protector appropriate (Please state)																									
Skin Inspection – tick when pressure areas checked – record N if no damage present, R for redness, D for discolouration U for pressure ulcer or E for excoriation/moisture. Record any damage in evaluation overleaf - state where and give description.																									
All pressure areas checked (top to toe-only tick when done)																									
Redness/discolouration/pressure ulcer present																									
Tick if skin protection applied (state)																									
Keep moving – tick which position patient been repositioned to when encouraged/assisted to move																									
BED Right side (30° tilt)																									
Left side (30° tilt)																									
Back																									
Sliding sheet required																									
Independent																									
CHAIR																									
Incontinence – tick if patient incontinent of urine/faeces or both																									
Urine (Specify Pad and pants if in use)																									
Bowels																									
Nutrition –Ensure where appropriate food record chart, fluid balance and supplement recording sheet used. Document current diet using the appropriate code – ND =Normal Diet / ED = Energy Dense / MC = Modified Consistency / NBM = Nil by Mouth / E-Enteral feeding **- If diet changes enter change alongside date of change**																									
Diet / fluids																									
Initials	AC	AC	AC	AC	[illegible]	[illegible]	MH	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]										
Designation	NA	NA	NA	NA	[illegible]	[illegible]	SN	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]										

CARE & Documentation Record

Completed – Re – Refused – A – asleep N/A – not applicable

V – variance – record on evaluation sheet on page 2

Write or attach label
HCR No: .....
CHI No: .....
Surname: GALLOWAY
Forename: STEPHEN Sex: .....
Address: .....
Date of Birth: .....
.....

Ayrshire & Arran

It is not necessary to write in every box every time a care and comfort round is undertaken, only complete as required using the codes above

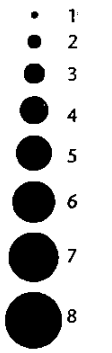
| CARE & COMFORT ROUND | | |

Neurological Observations

Date																									
Time																									
COMA SCALE	E	Spontaneously	4																						Eyes closed by swelling = C
	Eyes open	To speech	3																						
		To pain	2																						
		none	1																						
	V	Oriented	5																						Endotracheal tube or tracheostomy = Y
	Best verbal response	Confused	4																						
		Inappropriate words	3																						
		Incomprehensible sounds	2																						
		None	1																						
	M	Obeys	6																						Usually record the best arm response
	Best motor response	Localises	5																						
		Flexion - withdrawal	4																						
		Flexion - abnormal	3																						
		Extension to pain	2																						
		None	1																						
	TOTAL SCORE																								
PUPILS	R	Size																							+ reacts - no reaction c eyes closed
		Reaction																							
	L	Size																							
		Reaction																							
LIMB MOVEMENT	ARMS	Normal power																							Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness																							
		Severe weakness																							
		Spastic flexion																							
		Extension																							
		No response																							
	LEGS	Normal power																							
		Mild weakness																							
		Severe weakness																							
		Spastic flexion																							
		Extension																							
		No response																							

Glasgow Coma Scale

Pupil size (mm)



Pain Score

Ask the patient to rate his/her pain by choosing a number between 0 and 10.
Use the diagram below to assist the patient. If the patient's pain is chronic, use the generic tool. If the patient is unable to communicate, use the observational tool.

0	1	2	3	4	5	6	7	8	9	10	A
No Pain	Mild Pain			Moderate Pain			Severe Pain				Asleep

Nausea and Vomiting
0 - None
1 - Mild (Not distressing - no retching/ vomiting)
2 - Moderate (Troublesome - occasional retching/vomiting)
3 - Severe (Distressing - frequent retching/ vomiting)

Physiological Parameter	NEWS - NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92 - 93	94-95	>96			
Any Supplementary Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V,P or U

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

Medical Photography • NC17-00057

STA5653PS

NEWS
National Early Warning Score

	Date	Ward
Admitted	4/11/18	CAU
Transferred		
Transferred		

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

NHS Ayrshire & Arran

Special Instructions - to be completed by Medical Team

A total NEWS score of _____ due to _____ or individual parameter range of _____
is acceptable for this patient because _____

_____

Please escalate if _____

_____

Print _____ Sign _____ Designation _____
Date _____ Time _____ *(only valid if signed and dated)*

A total NEWS score of _____ due to _____ or individual parameter range of _____
is acceptable for this patient because _____

_____

Please escalate if _____

_____

Print _____ Sign _____ Designation _____
Date _____ Time _____ *(only valid if signed and dated)*

See NEWS Actions Reference Tool for local escalation policy

News score	Frequency of monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations
Aggregate 1-4	Minimum 4 hourly	• Inform trained nurse • Trained Nurse assessment - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate
Aggregate 5 or more *or* any single red score	Increase frequency to a minimum of 1 hourly	• Trained Nurse assessment • Inform medical team caring for the patient and dual response • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately • Inform medical team caring for the patient - this should be at least senior medical staff level. If unable to attend promptly, escalate to consultant or Emergency Response Team. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. • Consider referral to high dependency or ITU.

Neurological Observations

| | | |

NEWS
National Early Warning Score

	Date	Ward
Admitted		
Transferred		
Transferred		

N
CHI: 1406650854
D Galloway, Stephen
28 Redburn Place
C Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XH1468158

NHS
Ayrshire & Arran

Special Instructions - to be completed by Medical Team

A total NEWS score of _____ due to _____ or individual parameter range of _____
is acceptable for this patient because _____

Please escalate if _____

Print _____ Sign _____ Designation _____
Date _____ Time _____ *(only valid if signed and dated)*

A total NEWS score of _____ due to _____ or individual parameter range of _____
is acceptable for this patient because _____

Please escalate if _____

Print _____ Sign _____ Designation _____
Date _____ Time _____ *(only valid if signed and dated)*

See NEWS Actions Reference Tool for local escalation policy

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Aggregate 5 or more *or* any single red score	Increase frequency to a minimum of 1 hourly	• Trained Nurse assessment • Inform medical team caring for the patient and dual response • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately • Inform medical team caring for the patient - this should be at least senior medical staff level. If unable to attend promptly, escalate to consultant or Emergency Response Team. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. • Consider referral to high dependency or ITU.

Does the patient require a PVC? Consider DRIFT!

Diagnostics	Resus	IV meds	Fluids	Transfusion
Does the patient require a PVC for diagnostic purposes eg CT Scan?	Is the patient at risk of a cardiac or respiratory arrest that may require resuscitation?	Does the patient require IV medication? **(Can this be switched to the oral route?)**	Does the patient require IV Fluids? **(Are they now able to receive sufficient fluids by the oral route?)**	Does the patient require transfusion of any blood products?

Patient meets 1 or more requirements of DRIFT

Yes (PVC required)	No (PVC not required)
• Complete Insertion sticker • Maintain PVC daily	• Encourage diet and fluids where appropriate

PVC Insertion Bundle

Place insertion sticker here

If not available Addressogram

If the insertion sticker is unavailable please complete the following, if known:

Date inserted.....

By (designation)..... Ward.....

Site..... Colour.....

Maintenance Bundle (please circle all that applies eg Ⓓ R I F T)

Hand hygiene must be performed before & after all procedures. Prior to access, the hub must be scrubbed with 2% CHG & 70% IPA (Clinell wipe (Green))

Day	Date	PVC has been insitu < 72 hours	Patient requires a PVC because: (see above)	The PVC dressing appears:	The PVC site appears:	The PVC was:	Initials	Ward
1	...../...../.....	(< 72hours)	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		
2	...../...../.....	(< 72hours)	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		
3	...../...../.....	(< 72hours)	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		
4	...../...../.....	Document risk assess (> 72hours)	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		
5	...../...../.....	Document risk assess (> 72hours)	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		

NB If the PVC site is inflamed, please remove and obtain a swab (charcoal swab)

Does the patient require a PVC? Consid DRIFT!

Diagnostics	Resus	IV meds	Fluids	Transfusion
Does the patient require a PVC for diagnostic purposes eg CT Scan?	Is the patient at risk of a cardiac or respiratory arrest that may require resuscitation?	Does the patient require IV medication? (Can this be switched to the oral route?)	Does the patient require IV Fluids? (Are they now able to receive sufficient fluids by the oral route?)	Does the patient require transfusion of any blood products?

Patient meets 1 or more requirements of DRIFT

Yes (PVC required)	No (PVC not required)
• Complete Insertion sticker • Maintain PVC daily	• Encourage diet and fluids where appropriate

PVC Insertion Bundle

Name Stephen Galloway CHI 1406650854

Date 4/11/18 Time 16:20

Insertion Site (L) wrist Colour Pink

Inserted by K Gallacher Grade 3

1st attempt ☑ 2nd attempt ☐ 3rd attempt ☐

Insertion Criteria (circle those that apply)

Diagnostics	Resus	IV meds	Fluids	Transfusion
Clean Field	☑	Hand Hygiene	☑	
Skin asepsis	☑	Non touch technique	☑	

Maintenance Bundle (please circle all that applies eg D R I F T)

Hand hygiene must be performed before & after all procedures. Prior to access, the hub must be scrubbed with 2% CHG & 70% IPA (Clinell wipe (Green))

Day	Date	PVC has been insitu < 72 hours	Patient requires a PVC because: (see above)	The PVC dressing appears:	The PVC site appears:	The PVC was:	Initials	Ward
1	5/11/18	< 72hours	D R (I) F T	(Intact) / Not Intact And Replaced	(Healthy) / Signs of Infection	(Left Insitu) / Removed	KM	AC/CAU
2	...../...../.....	< 72hours	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		
3	...../...../.....	< 72hours	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		
4	...../...../.....	Document risk assess. > 72hours	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		
5	...../...../.....	Document risk assess > 72hours	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		

NB If the PVC site is inflamed, please remove and obtain a swab (charcoal swab)

Does the patient require a PVC? Consider DRIFT!

Diagnostics	Resus	IV meds	Fluids	Transfusion
Does the patient require a PVC for diagnostic purposes eg CT Scan?	Is the patient at risk of a cardiac or respiratory arrest that may require resuscitation?	Does the patient require IV medication? **(Can this be switched to the oral route?)**	Does the patient require IV Fluids? **(Are they now able to receive sufficient fluids by the oral route?)**	Does the patient require transfusion of any blood products?

Patient meets 1 or more requirements of DRIFT

Yes (PVC required)	No (PVC not required)
• Complete Insertion sticker • Maintain PVC daily	• Encourage diet and fluids where appropriate

PVC Insertion Bundle

Place insertion sticker here

If not available Addressogram

If the insertion sticker is unavailable please complete the following, if known:

Date inserted.....

By (designation)..... Ward.....

Site..... Colour.....

Maintenance Bundle (please circle all that applies eg (D) R I F T)

Hand hygiene must be performed before & after all procedures. Prior to access, the hub must be scrubbed with 2% CHG & 70% IPA (Clinell wipe (Green))

Day	Date	PVC has been insitu < 72 hours	Patient requires a PVC because: (see above)	The PVC dressing appears:	The PVC site appears:	The PVC was:	Initials	Ward
1	...../...../.....	(< 72hours)	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		
2	...../...../.....	(< 72hours)	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		
3	...../...../.....	(< 72hours)	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		
4	...../...../.....	Document risk assess (>72hours)	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		
5	...../...../.....	Document risk assess (>72hours)	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		

NB If the PVC site is inflamed, please remove and obtain a swab (charcoal swab)

Does the patient require a PVC? Consider DRIFT!

Diagnostics	Resus	IV meds	Fluids	Transfusion
Does the patient require a PVC for diagnostic purposes eg CT Scan?	Is the patient at risk of a cardiac or respiratory arrest that may require resuscitation?	Does the patient require IV medication? **(Can this be switched to the oral route?)**	Does the patient require IV Fluids? **(Are they now able to receive sufficient fluids by the oral route?)**	Does the patient require transfusion of any blood products?

Patient meets 1 or more requirements of DRIFT

Yes (PVC required)	No (PVC not required)
• Complete Insertion sticker • Maintain PVC daily	• Encourage diet and fluids where appropriate

PVC Ins

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

If the insertion sticker is unavailable please complete the following, if known:

Date inserted 6/11/18

By (designation) CSW Ward CAU

Site L Arm Colour Pink

Maintenance Bundle (please circle all that applies eg D R I F T)

Hand hygiene must be performed before & after all procedures. Prior to access, the hub must be scrubbed with 2% CHG & 70% IPA (Clinell wipe (Green))

Day	Date	PVC has been insitu < 72 hours	Patient requires a PVC because: (see above)	The PVC dressing appears:	The PVC site appears:	The PVC was:	Initials	Ward
1	6/11/18	< 72hours	D R (I) F T	(Intact) Not Intact And Replaced	(Healthy) Signs of Infection	(Left Insitu) Removed	[illegible]	CAU
2	7/11/18	< 72hours	D R (I) F T	(Intact) Not Intact And Replaced	(Healthy) Signs of Infection	Left Insitu (Removed)	?	KPA Amb
3	...../...../.....	< 72hours	D R I F T	Intact Not Intact And Replaced	Healthy Signs of Infection	Left Insitu Removed		
4	...../...../.....	Document risk assess (> 72hours)	D R I F T	Intact Not Intact And Replaced	Healthy Signs of Infection	Left Insitu Removed		
5	...../...../.....	Document risk assess (> 72hours)	D R I F T	Intact Not Intact And Replaced	Healthy Signs of Infection	Left Insitu Removed		

NB If the PVC site is inflamed, please remove and obtain a swab (charcoal swab)

Does the patient require a PVC? Consider DRIFT!

Diagnostics	Resus	IV meds	Fluids	Transfusion
Does the patient require a PVC for diagnostic purposes eg CT Scan?	Is the patient at risk of a cardiac or respiratory arrest that may require resuscitation?	Does the patient require IV medication? **(Can this be switched to the oral route?)**	Does the patient require IV Fluids? **(Are they now able to receive sufficient fluids by the oral route?)**	Does the patient require transfusion of any blood products?

Patient meets 1 or more requirements of DRIFT

Yes (PVC required)	No (PVC not required)
• Complete Insertion sticker • Maintain PVC daily	• Encourage diet and fluids where appropriate

PVC Insertion Bundle

Place insertion sticker here

If not available Addressogram

If the insertion sticker is unavailable please complete the following, if known:

Date inserted.....

By (designation)..... Ward.....

Site..... Colour.....

Maintenance Bundle (please circle all that applies eg (D) R I F T)

Hand hygiene must be performed before & after all procedures. Prior to access, the hub must be scrubbed with 2% CHG & 70% IPA (Clinell wipe (Green))

Day	Date	PVC has been insitu < 72 hours	Patient requires a PVC because: (see above)	The PVC dressing appears:	The PVC site appears:	The PVC was:	Initials	Ward
1	...../...../.....	(< 72hours)	(D) R I F T	(Intact) / Not Intact And Replaced	(Healthy) / Signs of Infection	(Left Insitu) / Removed		
2	...../...../.....	(< 72hours)	(D) R I F T	(Intact) / Not Intact And Replaced	(Healthy) / Signs of Infection	(Left Insitu) / Removed		
3	...../...../.....	(< 72hours)	(D) R I F T	(Intact) / Not Intact And Replaced	(Healthy) / Signs of Infection	(Left Insitu) / Removed		
4	...../...../.....	Document risk assess (> 72hours)	(D) R I F T	(Intact) / Not Intact And Replaced	(Healthy) / Signs of Infection	(Left Insitu) / Removed		
5	...../...../.....	Document risk assess (> 72hours)	(D) R I F T	(Intact) / Not Intact And Replaced	(Healthy) / Signs of Infection	(Left Insitu) / Removed		

NB If the PVC site is inflamed, please remove and obtain a [illegible] (charcoal swab)

Does the patient require a PVC? Consider DRIFT!

Diagnostics	Resus	IV meds	Fluids	Transfusion
Does the patient require a PVC for diagnostic purposes eg CT Scan?	Is the patient at risk of a cardiac or respiratory arrest that may require resuscitation?	Does the patient require IV medication? (Can this be switched to the oral route?)	Does the patient require IV Fluids? (Are they now able to receive sufficient fluids by the oral route?)	Does the patient require transfusion of any blood products?

Patient meets 1 or more requirements of DRIFT

Yes (PVC required)	No (PVC not required)
• Complete Insertion sticker • Maintain PVC daily	• Encourage diet and fluids where appropriate

PV 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

r here

sogram

If the insertion sticker is unavailable please complete the following, if known:

Date inserted 21.01.2019.

By (designation) R Leskol Ward AMB CAU

Site (L) ACF Colour GREEN

Maintenance Bundle (please circle all that applies eg (D) R I F T)

Hand hygiene must be performed before & after all procedures. Prior to access, the hub must be scrubbed with 2% CHG & 70% IPA (Clinell wipe (Green))

Day	Date	PVC has been insitu < 72 hours	Patient requires a PVC because: (see above)	The PVC dressing appears:	The PVC site appears:	The PVC was:	Initials	Ward
1	...../...../.....	(< 72hours)	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		
2	...../...../.....	(< 72hours)	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		
3	...../...../.....	(< 72hours)	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		
4	...../...../.....	Document risk assess (> 72hours)	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		
5	...../...../.....	Document risk assess (> 72hours)	D R I F T	Intact / Not Intact And Replaced	Healthy / Signs of Infection	Left Insitu / Removed		

NB If the PVC site is inflamed, please remove and obtain a swab (charcoal swab)

NHS
Ayrshire
& Arran

SMOKE FREE GROUNDS POLICY

DISCLAIMER GUIDANCE

Please note as part of the nursing admission documentation all those who smoke should be referred to the Fresh Air-shire team (by placing a patient sticker onto a referral card and then into the black box) so that they can provide information about the smoke free grounds policy and help the patient to manage their smoking while in hospital

Write or attach label

HCR No: .....
CHI No: .....
Surname: Galloway
Forename: Stuart Sex: .....
Address: .....
.....
Date of Birth: .....

Smoke Free Grounds Policy

Patient Disclaimer

Hospital:	XH
Ward/Station/Dept:	CA
Patient Name:	

I _____(print name) have been provided with information regarding the management of smoking in hospital in compliance with the NHS Ayrshire & Arran Smoke Free Grounds Policy and I understand that I am not permitted to smoke anywhere on NHS A&A grounds.

I have read and understood this information. I have been advised against leaving the ward to smoke. I understand that there are risks associated with leaving the ward/department. In particular I understand that my decision will affect the medical attention I receive and that NHS Ayrshire & Arran cannot provide medical care and attention to me whilst I am absent from the ward/department. I therefore accept that the staff cannot be responsible for my care whilst I am absent from the ward and hospital grounds.

Patient Signature:	[signature]	Witness Signature:	[signature]
Date:	7 1 18	Date:	7 1 18
Time:	0940	Time:	0940

PLEASE FILE THIS FORM IN NURSING NOTES ENSURING CIRCUMSTANCES ARE FULLY DOCUMENTED

NHS Ayrshire & Arran

Cleansing & Dressing - Care Plan

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

Care Plan code: D

Patient Problem/Need
Patient is unable to achieve his/her own hygiene requirements or requires prompting due to .....

Goal
To maintain privacy, dignity and choice ensuring the patient's cleanliness and comfort at all times

Date	Time	Init's	Planned Nursing Interventions	Discontinued Date/Time	Init's
22-1-19	2335	FS	Assist patient as per their individual needs and encourage participation where possible (eg. oral care, hair care, shaving, hand washing) Independant		
22-1-19	2335	FS	Ensure that adequate opportunity for hand washing is provided / offered to the patient especially following toileting and before meals.		
			1 or 2 nurses to help with hygiene needs. Please state: 1 ☐ 2 ☐		
			Provide: e.g. Bed bath / General bath / Shower or assisted wash daily – patient choice where suitable and record interventions and outcomes daily in the 'evaluation of care' section of in-patient booklet. (Remember to document if a patient has refused intervention)		
22-1-19	2335	FS	Ensure that the patient's privacy and dignity are respected throughout all interventions		
			Assess condition of skin when washing (including feet). Commence on pressure area care plan if deemed necessary)		
			Change bed linen / gown / patients own night clothes as required – patient choice and document daily in the 'evaluation of care'.		
			Refer to Occupational Therapist and liaise re specialist instructions		
			Ensure oral assessment and intervention tool has been completed if indicated		
			This care plan has been discussed and agreed with the patient as appropriate.		

			if clinically indicated		
			Collect sputum sample for culture and sensitivity if clinically indicated		
			Collect stool sample for culture and sensitivity if clinically indicated		
			Sample one☐ Two ☐ Three ☐		
			This care plan has been discussed and agreed with the patient and / or relatives as appropriate		

NHS Ayrshire & Arran

Write or attach label

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Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

Emergency Admission Care Plan - Medical

Activity of living maintaining safe environment

Care Plan Code:

Patient Problem/Need
Patient has been admitted as an emergency to AMAU with... Cough

Goal
To monitor and alleviate symptoms
To minimise and treat complications

Date	Time	Intls	Planned Nursing Interventions	Discontinued Date/Time	Intls
22-1-19	2355	FS	Orientate patient & relatives to ward area		
22-1-19	2355	FS	Monitor and record vital signs on admission to ward and continue to assess as clinically indicated/as per MEWS		
			Ensure routine bloods inc..... ECG, BM & CXR carried out as per plan.		
			Commence Neurological observations as per clinical presentation and monitor as per MEWS		
22-1-19	2355	FS	Ensure all prescribed medications are given as per medical instruction and monitor effect		
22-1-19	2355	FS	Maintain safe effective intravenous access as per protocol using cannula monitoring chart		
			Commence on intravenous fluids as prescribed or indicated & commence accurate fluid balance		
			Commence on prescribed O_2, titrate to clinical requirements and record on oxygen prescription chart.		
			Record Erect and supine Blood Pressure & inform medics of any defecit.		
			Commence patient on Telemetry monitoring as per medical plan. Box.....commenced.....		
			Collect midstream sample of urine for culture and sensitivity		

NHS Ayrshire & Arran

Breathing - Care Plan

Write or attach label

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

Care Plan Code: B

Patient Problem/Need
The patient is experiencing breathing difficulties due to..... (e.g. post-op, chest infection, pleural effusion, anaemia, COPD, heart failure etc)
Goal
To establish normal or near normal pattern of breathing for patient prior to current episode

Date	Time	Intls	Planned Nursing Interventions	Discontinued Date/Time	Intls
23/1	0240	NS	Offer emotional support maintaining privacy and dignity throughout all interventions.		
23/1	0240	NS	Position patient comfortably (consider optimum position for air entry where appropriate, e.g. lie on unaffected side or leaning forward) • place them near an open window, • use a fan, • position sitting up supported with pillows • position bed near the toilet.		
23/1	0240	NS	Where possible encourage movement/mobility to help move and clear secretions		
23/1	0240	NS	Observe for signs of hypoxia / hypercapnia e.g. confusion, agitation, coma		
23/1	0240	NS	Administer inhalers/nebuliser therapy as prescribed. Monitor and note inhaled technique with inhaled therapies and compliance, if appropriate. (COPD patients should receive nebulisers only via compressor, see O_2 guideline)		
/			If further support is required for patients with poor inhaler technique, contact Clinical Nurse Specialists or designated pharmacist		
/			Commence on prescribed O_2, titrate to clinical requirements and record on oxygen prescription chart.		
/			If patient has a productive cough that is not responding to antibiotics, consider sending sample for culture and sensitivity (C&S) – 3 samples on consecutive mornings		
23/1	0240	NS	If patient has a productive cough that is not responding to antibiotics, consider sending samples for Alcohol-Acid Fast Bacilli (AAFB) to check for Tuberculosis if circumstances have given rise to suspicion to merit this test, – 3 samples on consecutive mornings		
			Refer to Clinical Nurse Specialist eg Respiratory, Heart failure, if admitted with acute exacerbation of COPD, asthma or heart failure		
/			Refer to physiotherapist if required		
			This care plan has been discussed and agreed with the patient and /or carer/relative as appropriate.		

CHI: 1406650854
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Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158
Date of Birth

Ward DSU

Date & Time	Care plan Code	Nursing Evaluation	Initials
		with A.AMAWS. Not scoring.	
		Off ward with family for hour.	TF
1815		1-1 care given to ward staff. G4 contacted & updated that patient is being transferred to ward 310 tonight.	DM.
22.1.19. 1900	A	Patient transferred from DSU. Alert + oriented to ward.	
		News stable.	
		No issue.	
		Independent - States PAs intact	JM
22.1.19.	V	News as charted.	
2355	A	Refusing diazepam & paboruex. Not scoring on CIWAWS at present.	
	N	States skin intact.	
	H/E	Independant. No issues.	FS.
23.1.19	A	Meds as charted	
	D	Independent	
	E/H	Independent to toilet	
	P	No issues	
	R	Eating and drinking well	
	V	News stable.	
	X	Cannula removed	
	A	for dc home. Own transport	
		arranged. Will return for	
		d/c Meds.	JM
1310	A.	G4 contacted to make aware	
		patient has been discharged	JM

Ward DSU

Nursing Care Evaluation

Date & Time	Care plan Code	Nursing Evaluation	Initials
		morning News ① HR 91. Meds given as charted. IVFIs complete. Hyp UNCHANGED ✱ 2125h —	
10⁵⁸		Independent with personal hygiene. No complaints offered. Vital obs as charted NEWS 2. SpO² 94%, pulse 91bpm. Awaiting review	TF
1230		Reviewed by Dr Gagan medics, to remain another night, to continue medication as prescribed. To commence on GMAWS and pabinax, therefore for transfer to ward, bed manager informed, for bed later today.	DRoone
1235		for bloods in am	DRoone
12⁵⁰		IV pabinnex given as charted. Awaiting prescription of diazepam to be completed. Patient states he has not had a drink in 6 weeks. AAMAWS appropriate. Awaiting review.	
13⁴⁰		AAMAWS completed - pt still to be on GMAWS + pabinex even though medical staff aware he has not drank in 6 weeks 10mg diazepam given as per AAMAWS. Contacted C4 security on 0800 8400783 and informed patient is in hospital	TF
16⁵⁰		for transfer to 3D - no bed available	TF
		for transfer to 2D - sister Marion to call back	TF
16²⁰		Patient stated that he spat the last diazepam out. Not happy	

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Ward CAU

Date & Time	Care plan Code	Nursing Evaluation	Initials
21.1.19	A	Admitted to CAU, Orientated	
1800		Orientated	JT
	V	News as charted	
	R	Tolerating diet & fluids	
21/1/19		Patient for transfer to day surgery unit.	
2205	V	Observations Stable as charted. NEWS = 2	
		as oxygen saturations 97%. and heart	
		rate 92 beats per minute.	
		Patient comfortable.	
		Please start IVF once transfered to DSU	AF
		Handover given	AF
		Evening anoxication given as prescribed.	AF
2225		Transfer from A+E was over	
		fifteen minutes waiting due to	
		layout of unit have had to	
		put in with Pre & Post-op	
		Penny Bed nurses aware of this.	
		Overhead to unit & buzzer system	
	2230	Obs as charted, news (2) SpO2 96%	
		O/A, HR 102 BPM. IV fluids	
		commenced as charted. coffee	
		given. No complaints offered at	
		this time. MJ — Uncannulas #22G,	
	2245	S.O.B., wheeze & cough +++.	
		2% Smg Saline neb given &	
		advised to use inhaler. MJ —	
	0215	Mobile indep to toilet in ward.	
		No complaints. Cough settled. MJ	
	0700	Slept on & off overnight. Feeling	
		& looking much better this	

Nursing Care Evaluation

Ward Round Instructions / Goals of Care

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Ward CAU

Date & Time	Ward Round Instructions	CLD	EDD	Initials
	- Steroid			
	- cult pt spuo			
	- worsening acuce			
	- oral amox.			
	- urine for pneum + cano.			
	- prn / salbutamol			
	- Spuo			
	- current pyrexic			
23.1.19.	Reviewed by team - Plan -			
	Check bloods. Home today			
	with oral antibiotics			JM

Ward Round Instructions

Initial Presentation and Plan

Write or attach label

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Ward CRU

Date & Time	Immediate presenting history (inc GP, ED or clinic)	Initials
21.1.19 1800	Patient brought to Amb care. News a) Cracked. Blood + ECG obtained Await r/v.	

Medical/ANP Initial Plan

21.1.19 1810 Reviewed by medics - ?UTI
?undiagnosed COPD
Plan - Blood
- ECG
- CXR
- Sputum
Reviewed by Consultant - Imp - NI COPD
Plan - bloods

Initial Presentation and Plan

Care Plans and Monitoring Charts Evaluation

Write or attach label

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Code	Care Plan / Monitoring Chart
A	Admitted as an emergency
B	Breathing
C	Catheter
D	Cleansing and dressing
E	Elimination
F	Falls
G	Bedrails
H	Mobilising
J	Communication
K	Pre - operative
L	Post - operative
M	Wound Management
N	Pressure area care
O	Oral Hygiene
P	Pain Management
R	MUST - Eating and Drinking
S	Emotional Wellbeing/Anxiety
T	MRSA
V	MEWS
W	Fluid Balance Chart
X	PVC Chart
Y	Investigations
Z	Cognitive impairment

Code	Additional specific care plans / monitoring Charts
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
21	

Care Plans

Referrals to Multidisciplinary Team During Admission

Date	Initials of staff making referral	Referrals	Contact Number/ Page	Date Reviewed	Initials
		Alcohol Liaison Team			
		Community Learning Disability Team			
		Community Mental Health Team			
		Community Mental Health Team Elderly			
		Community Nurse			
		Community Psychiatric Liaison Team			
		Community Psychiatric Liaison Team Elderly			
		Dental			
		Diabetic Team			
		Dietitian			
		Discharge Co-ordinator			
		Fresh Air-shire			
		Home Care Organiser			
		Intermediate Care and Enablement Services			
		Occupational Therapist			
		Palliative Care Team			
		Pain Team			
		Pharmacist			
		Physiotherapist			
		Podiatrist			
		Psychiatric Liaison Team			
		Speech and Language Therapist			
		Social Worker			
		Specialist Nurse			
		Tissue Viability			
		Other - please specify			

Mobilising - Care Plan

N/A

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Date of Birth.....

Patient Problem/Need
Patient has restricted mobility/mobility is deteriorating due to.....
Goal
To optimise ability to mobilise safely and maintain independence as much as possible

Date	Time	Initial	Planned Nursing Interventions	Discontinued Date/Time	Initial
			Refer to moving and handling risk assessment tool and plan care accordingly.		
			Mobilise/transfer with assistance of one/two handlers.		
			Mobilise/transfer with supervision.		
			Mobilising with appropriate handling equipment and/or aids, please state:-		
			• Walking stick one/two		
			• Tripod/quad		
			• Zimmer frame/rolator		
			• Wheel chair		
			• Hoist aid (specify equipment used)		
			• Other (please specify)		
			Refer to physiotherapist and action specialist requirements.		
			This care plan has been discussed and agreed with the patient and/or carer/relative as appropriate.		

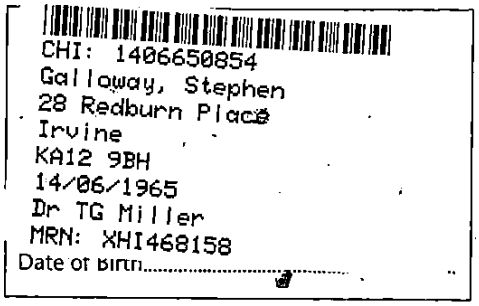
Risk Assessment

MOVING AND HANDLING CARE PLAN

Date:	21.1.19	22.1.19				
1. Moving in bed:						
a) Independent	a) ✓	✓				
b) Handlers and sliding sheets required to move in bed - specify number of handlers in grid	b)					
c) Specify any additional equipment required in grid	c)					
2. Sitting to Standing:						
a) Independent	a) ✓	✓				
b) Requires assistance from sit/stand to sit? Specify number of handlers in grid	b)					
c) Also requires aids. Specify equipment in grid	c)					
4. Transfers: (chair / wheelchair / commode / toilet / bed)						
a) Independent or with minimal supervision	a) ✓	✓				
b) Assistance required from handlers specify number of handlers in grid.	b)					
c) Equipment required - specify equipment in grid	c)					
4. Adjusting Clothing						
a) Independent or minimal supervision	a) ✓	✓				
b) Can use support/grab rails while assistance is given with clothing	b)					
c) Requires support from Handler(s) while another assists with clothing	c)					
d) Requires equipment, specify equipment in grid	d)					
5. Repositioning in chair / wheelchair:						
a) Independent or minimal supervision	a) ✓	✓				
b) Assistance from handler(s), specify number in grid	b)					
c) Specify other aids or equipment required in grid	c)					
6. Mobilising:	Documented in Mobility Care Plan					
Assessors initials	[illegible]	AS				

If it is decided to stand, transfer or mobilise a patient requiring assistance of more than 2 handlers, without equipment, a detailed assessment outlining the decision making process must be documented in the mobility careplan.

Moving & Handling
Patient Risk Assessment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All Patients:

Sliding aids **must** be used bed to trolley/bed unless the patient transfers independently
A hoist **must** be used if assistance is required from the floor
A hoist **must** be used for bathing unless independently mobile
Hoists are for lifting patients and must not be used for transport between rooms

Special Alerts: • Date:	21.1.19	22.1.19				
Overweight / Obese (BMI definition)						
Very tall (>185cm in height)						
Restricted use of limbs						
Poor standing ability						
Sedation or lethargy						
Irrational behaviour / confusion						
Unable to co-operate						
Acute pain						

Assessment of Risk:

Low Risk: Independently mobile / supervision only required. Aids required should be specified in care plan

Moderate Risk: Requires physical assistance from one or more handlers. Is able to stand or partially bear weight and has no more than one special alert.

High Risk: (a) Is unable to bear weight and requires assistance.
(b) 2 or more special alerts present and requires assistance.

Aids, equipment and a minimum of 2 handlers recommended to move a patient.

Specify Level of Risk

Date:	21.1.19	22.1.19				
LOW RISK	✓	✓				
MODERATE RISK						
HIGH RISK						
Assessor's Initials	L	FS				

If a hoist or standing aid is required please specify:

Sling type:		Size:		Manufacturer:	

Additional Comments:

Risk Assessment

Safe Use of Bed Rails - Care Plan

N/A

Write or attach label

HCR No:
CHI No:
Surname:
Forename: Sex:
Address:
Date of Birth:

Patient Problem/Need
The patient is at risk of falling out of bed due to (e.g. cognitive or physical condition)

Goal
To promote and maintain patient safety and reduce the risk of falling out of bed

Date	Time	Initial	Planned Nursing Interventions	Discontinued Date/Time	Initi
			Ensure assessment is made on admission, when patient's condition changes, and weekly as a minimum.		
			Ensure rationale for decision made re; the use of bedrails is clearly documented.		
			Consider psychological effects of bedrail usage on patient and where appropriate ensure the patient's consent to their use.		
			Ensure risk of entrapment is minimised by careful positioning of patient prior to operating bedrails.		
			If detachable bedrails used, ensure the gap between the top end bedrail and head of bed is less than 6cm or more than 25cm.		
			If detachable bedrails used, ensure the gap between the bottom end of bedrail and foot of bed is more than 25cm.		
			Continually monitor risk of patient climbing over the top of bedrails and assess the use of bedrails as necessary.		
			Discuss with the patient, the need to share information with other nurses and health care workers re; the use of bedrails, and document within the nursing documentation whether the patient consents to display information at the bed space.		
			Provide Falls/Use of Bedrails information leaflet to patient. Where the patient is incapacitated, ensure that relative/carer is given a leaflet and information about the assessment for bedrails is provided.		
			Ensure all actions, including discussions with relative/ carer are documented.		
			Refer to the Safe Use of Bedrails in Adult In-Patient Settings Guideline for further guidance on the management of bedrails.		
			Re-assess the need for bedrail use at least weekly or as the patient's condition indicates and document on the risk assessment chart.		
			This care plan has been discussed and agreed with the patient as appropriate.		

Bedrails Algorithm

Complete the NHS Ayrshire and Arran Slips Trips and Falls Assessment Tool

Is the patient at risk of falling from bed/trolley?
NB: for patients at risk of climbing over bedrails, alternatives must be considered. See boxes 2+3

Yes

Patient understands purpose of the bedrails

- Patient consents to bedrail use → Bedrails could be used with caution. See boxes 1 + 3 below
- Patient declines bedrail use → Bedrails inappropriate see boxes 2+3

Patient does not understand purpose of bedrails due to .....

- Communication difficulties → Consider:
  - Referral to appropriate speciality e.g. audiology
  - Use of interpreter
  - Use of written or pictoral information
- Physical and/or cognitive condition → Consider actions in patient's best interest. See boxes 1, 2 + 3 below → Agree plan of care with Next of Kin and document outcome in nursing records

No

- Patient requests bedrails → Bedrails could be used with caution. See boxes 1 + 3 below
- Patient not requesting bedrails → Bedrails inappropriate see box 3

1. If bedrails are used consider:

- Risk of entrapment and harm to limbs
- Risk of patient climbing over the top
- The psychological effect of their use on the patient
- Ensure bed returned to lowest height after care delivery
- Use of the Dynamic mattress increases the height of the bed

2. Alternatives to bed rails

- Use of variable height bed
- Additional mattress/crash mat beside bed
- Close observation of patient
- Ensure bed returned to lowest height after care delivery
- Ensuring patient needs anticipated e.g. drinks are accessible, regular toileting, call bell to hand etc
- Nursing patient on mattress on the floor should be a last resort and safety checks should be made for hot pipes, electric sockets etc. Manual handling risk assessment for staff must be undertaken

3. Remember to document in nursing records:

- Date and time assessment made
- Rationale for decision made in care plan
- Actions taken, including discussion with Next of Kin
- Care planning

Assessment should be made:

- On admission
- If patient's condition changes
- Weekly

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Bedrails Risk Assessment

Date of admission: 21.1.19

Please assess ALL patient on admission to your ward/departments

- Each statement must be answered - Circle answer
- Complete Risk Assessment in conjunction with Bedrails Algorithm overleaf
- Refer to Guidelines - Safe Use of Bedrails in In-patient Settings & Falls Prevention
- Ensure that you are aware of the safety requirements when using a bedrail, you have undertaken a visual check of the bedrail and that you are satisfied that there are not obvious areas of faults

Re Assessment Occurs

- Weekly
- When the patient's condition changes (i.e. patient falls/post surgery/change in medication/cognitive state changes)

Ensure clear identification of a change in use of bedrails within documentation and at bed space i consent obtained from patient

Risk Factors	Ward: CAU Date: 21.1.19 Time: 1800	Ward: 3D Date: 22.1.19 Time: 2350	Ward: Date: Time:	Ward: Date: Time:
1. Is the patient at risk of **falling** from bed?	YES / NO	YES / NO	YES / NO	YES / NO
2. Is the patient at risk of **intentionally** climbing over the bedrails?	YES / NO	YES / NO	YES / NO	YES / NO
3. Is the patient at risk of **unintentionally** falling from the bed/trolley?	YES / NO	YES / NO	YES / NO	YES / NO
4. Does the patient **understand** the purpose of the bedrails? Consider communication difficulties and physical/Cognitive condition.	YES / NO / NA	YES / NO / NA	YES / NO / NA	YES / NO / NA
5. Does the patient **consent** to the use of bedrails?	YES / NO / NA	YES / NO / NA	YES / NO / NA	YES / NO / N
Has the Bedrails Algorithm been followed?	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
According to the Bedrails Algorithm are bedrails required / appropriate?	Yes ☐ No ☑	Yes ☐ No ☑	Yes ☐ No ☐	Yes ☐ No ☐
Bumpers required	Yes ☐ No ☑	Yes ☐ No ☑	Yes ☐ No ☐	Yes ☐ No ☐
Initials	L	fs		

If Yes, commence a Safe Use of Bedrails Care Plan. If No, state reason why bedrails are not required.

Risk Assessment

			Offer toileting facilities as appropriate.		
			Ensure that patient is cared for in an area proximal to toilet facilities, if possible.		
			Encourage family, if present, to sit with patient (as appropriate).		
			Encourage family/carers to report to nursing station when ending their visit.		
			Consider appropriate equipment in liaison with Physio and / or OT.		
			Ensure yellow sticker is inserted into patient's notes after each fall.		
			Patients who may be confused or have had repeated falls where possible should be cared for in an area within the ward that is within easy view of nursing staff.		
			Check on patient every 15 minutes.		
			Consider a higher level of supervision of the patient.		
			Consider the use of a low level variable height bed.		
			Above care plan has been discussed and agreed with the patient and / or family / carer		

Slips Trips & Falls - Care Plan

(To be used in conjunction with the falls for all bundle)

Problem Number: N/A

Write or attach label
HCR No:
CHI No:
Surname:
Forename: Sex:
Address:
Date of Birth

Patient Problem/Need
Patient is considered to be at risk of falling

Goal
To promote and maintain patient safety and reduce the risk of falls

Date	Time	Initial	Planned Nursing Interventions	Discontinued Date/Time	Initial
			Orientate patient and family/carers to ward environment on admission and each shift.		
			Ensure buzzer within reach.		
			Explain importance about calling for help when needed.		
			Ensure that bedside table and key belongings are within easy reach.		
			Ensure patient wears appropriate clothing and footwear.		
			Ensure that patient is wearing spectacles if appropriate.		
			Discuss with family/carers how to assist with interventions.		
			Ensure that patient/family receives an explanation of risk and the measures in place to minimise this risk and document outcome.		
			Ensure that standard bed frame is used and left in a low position with brakes on.		
			Select a chair that is the appropriate height and design for the patient (seek guidance from Physio and OT).		
			When in use ensure that chair/commode brakes are secure.		
			Ensure that area is illuminated appropriately at night time.		
			Liaise with medical team re: medication review.		
			Consider referral to Physiotherapy, Occupational Therapy, Social Work.		
			Monitor lying and standing blood pressure.		
			Supervise patient when transferring as per moving and handling risk assessment.		
			Supervise patient when mobilising as per moving and handling risk assessment.		

Falls for All Bundle

Please complete for all patients on admission

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1. 5Q's
   a. Has the patient fallen in the last 6 months – including during this admission? Yes ☐ No ☑
   b. Does that patient have cognitive impairment or possible delirium? Yes ☐ No ☑
   c. Does that patient attempt to walk alone although unsteady or unsafe? Yes ☐ No ☑
   d. Does the patient or their relative/s have fear or anxiety, Re falling? Yes ☐ No ☑
   e. Based on your clinical judgement, is this patient at high risk of falling? Yes ☐ No ☑

If yes to any of the above, the patient is deemed as a vulnerable patient and should be commenced on the more vulnerable falls bundle (recording of this is included in care and comfort rounding or alternatively should be recorded in the patients records).

Initials: JS

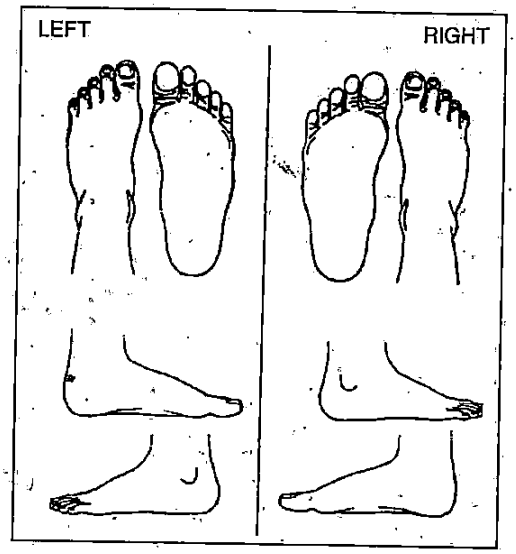
Date: 21.1.19

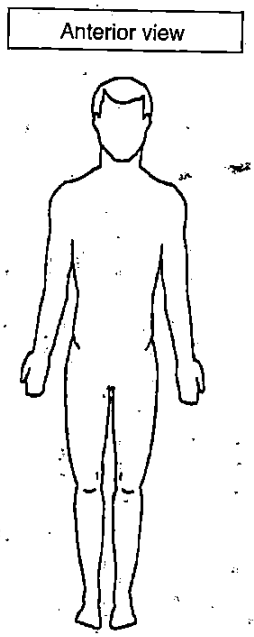
Time: 1800

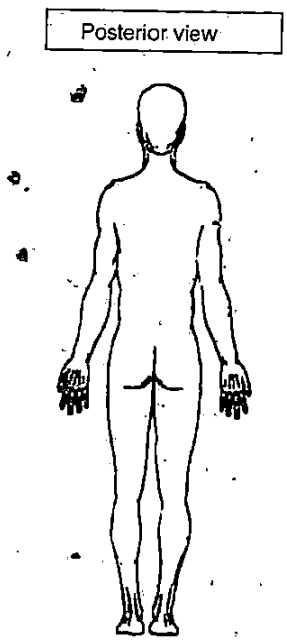
Risk Assessment

Pressure Ulcer Record

Indicate by circling, numbering and dating all pressure damage on diagrams, then complete box below. Initiate SSKIN care plan/wound assessment chart.







Date	Number of ulcer	Location of ulcer	Grade of ulcer	Datix Insert reference Grade 2-4	Logged on safety cross Grade 1-4	Signature	Print name

Scottish Adapted European Pressure Ulcer Advisory Panel) EPUAP - Pressure Ulcer Grading Tool - 2014

GRADE 1 Intact skin with non blanchable redness, usually over a bony prominence. Darker skin tones may not have visible blanching but the colour may differ from the surrounding skin. The area may be painful, firmer, softer, warmer or cooler than the surrounding tissue.

GRADE 2 Loss of epidermis/dermis presenting as a shallow open ulcer with red/pink wound bed without slough or bruising. May also present as a blister.

GRADE 3 Subcutaneous fat may be visible but bone tendon or muscle is not visible or palpable. Slough may be present but does not obscure the depth of tissue loss. Often includes undermining or tunnelling

GRADE 4 Extensive destruction with exposed or palpable bone, tendon or muscle. Slough may be present but does not obscure the depth of tissue loss. Often includes undermining or tunnelling.

DEEP TISSUE INJURY Epidermis is intact but the area appears purple or maroon or is a blood filled blister over a dark wound bed. Over time the skin will degrade and develop into deeper tissue loss.

UNGRADABLE: Full thickness skin loss where the depth of the ulcer is completely obscured by slough/necrosis. Until enough slough or necrotic tissue is removed to expose the base of the wound the true depth cannot be determined. It may be a grade 3 or 4 once debrided.

All acquired pressure ulcers graded 2 - 4 must be reported via Datix.
Refer to podiatry for at risk feet.

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Adapted Waterlow Pressure Area
- Risk Assessment Chart

More than one score can be used in each section

Complete assessment according to PPURA or if there is a change in individual's condition and repeat regularly according to local protocol

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N/A

		Date	22/1									
		Time	1250									
Sex												
Male 1 Female 2			1									
Age												
14 - 49	1											
50 - 64	2		2									
65 - 74	3											
75 - 80	4											
81+	5											
Build/Weight for Height *(BMI=weight in Kg/height in m²)*												
Average - BMI 20-24.9	0											
Above average - BMI 25-29.9	1		1									
Obese - BMI > 30	2											
Below average - BMI < 20	3											
Continence												
Complete/catheterised	0											
Urinary Incontinence	1		0									
Faecal incontinence	2											
Urinary and faecaly incontinent	3											
Skin Type - Visual Risks Area												
Healthy	0											
Tissue paper (thin/fragile)	1											
Dry (appears flaky)	1											
Oedamatous (puffy)	1		0									
Clammy (moist to touch) pyrexia	1											
Discoloured/Bruising/Grade 1	2											
Broken (established ulcer) Grade 2 - 4	3											
Mobility												
Fully mobile	0											
Restless/fidgety	1											
Apathetic (sedated/depressed/reluctant to move)	2											
Restricted (restricted by severe pain or disease)	3		0									
Bedbound (unconscious/unable to change position/traction)	4											
Chairbound (unable to leave chair without assistance)	5											
Special Risks - Tissue Malnutrition												
Multiple organ failure/terminal cachexia	8											
Single organ failure e.g. cardiac, renal, respiratory	5											
Peripheral vascular disease	5		—									
Anaemia = Hb < 8	2											
Smoking	1		1									
Special Risks - Neurological Deficit												
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6		—									
Special Risks - Surgery/Trauma												
On table > 2 hours (up to 48 hours post op)	5											
On table for up to 6 hours (up to 48 hours post op) provided the rate of recovery is normal)	5		—									
Orthopaedic/below waist/spinal	8											
Special Risks - Medication												
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4		—									
		Total Score	4									
		Initials	FS									

<10 Low Risk - Reassess weekly 10+ At Risk - Reassess twice weekly 15+ High Risk - Reassess on alternate days 20+ Very High Risk - Assess daily	• The Waterlow **must be reassessed** if the patient's condition changes /deteriorates and the plan of care should be reviewed at that point. • For patients who are in long term care, provided their condition is stable after one week of admission the Waterlow can be reassessed weekly/monthly

Risk Assessment

Risk Assessment

Oral Hygiene - Care Plan

N/A

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Pre Admission Status
Patient has undergone oral assessment and requires assistance with regular mouth care
Goal
For oral cavity to be clean, pink, moist and comfortable

Date	Time	Intls	Planned Nursing Interventions	Discontinued Date/Time	Initials
			Dental Referral		
			• If patient hasn't seen a dentist • If patient suffers from mouth pain • If evidence of ulceration/soreness on tongue • If evidence of ulceration, bleeding gums or whiteness in gums/soft tissues		
			Oral Care		
			If patient is able, prompt by providing adequate opportunity and support to carry out oral care.		
			If patient is dependent, ensure mouth care is offered and provided at regular intervals.		
			If patient has dentures supervise/help with cleaning them night and morning with mild soap and water; rinse dentures after meals. Dentures should be left out and soaked in sodium hypochlorite overnight or for at least 20 minutes, before rinsing and leaving in plain water for the rest of the time. Metal-based dentures should be soaked in chlorhexidine mouthwash.		
			Other Issues		
			If lips are dry apply emollient e.g. lubricating gel.		
			If tongue is dry and coated clean with soft toothbrush and toothpaste and offer frequent fluids.		
			If patient suffers from dry mouth offer frequent fluids and/or iced water. If symptoms persist refer to dentist.		
			If patient has difficulty swallowing you should supervise/help with cleaning teeth and/or dentures and oral cavity after each meal.		
			If patient is nil by mouth or has poor fluid or dietary intake or is dehydrated they may require 2-hourly mouthcare. Check whether oral problems contributing.		
			If patient is on an energy dense diet or prescribed supplements/snacks consider high fluoride toothpaste if have natural teeth.		
			This care plan has been discussed and agreed with the patient as appropriate.		

Oral Health Risk Assessment

Rapid Assessment Questions	Circle which is appropriate		Suggested outcome/actions if "Yes" circled
Does the patient need assistance in carrying out their own basic oral care?	Yes	No	If you have answered yes to any of these questions please complete full oral health risk assessment below and review 4-weekly
Does the patient need assistance taking care of their dentures?	Yes	No	
Is the patient suffering from mouth pain?	Yes	No	
What is your normal mouth care routine at home? (for initial assessment only)			Details
Are you having any problems with your teeth or mouth?			Details

Patient Assessment		Circle which is appropriate		Suggested outcome/actions if "Yes" circled
Smoking habits	Smoker? (which may increase risk of gum disease and oral cancer?	Yes	No	Note amount per day on profile Consider smoking cessation
Dexterity problems	Having difficulty holding toothbrush?	Yes	No	May need supervision/help with mouth care Consider OT adaptation
Cognitive function	Evidence of short-term memory loss and/or confusion?	Yes	No	May need supervision/help with mouth care

Oral Assessment - use tongue compressor and pen torch to examine oral cavity		Circle which is appropriate		Suggested nursing care If "Yes" circled
Lips	Dry/cracked?	Yes	No	Apply an emollient e.g. lubricating gel
Tongue	Dry/coated?	Yes	No	Clean with soft toothbrush and toothpaste Offer frequent fluids
	Evidence of ulceration/soreness?	Yes	No	If yes, refer to Public Dental Services (PDS)* or advise patient to contact their dentist on discharge
Gums / soft tissue	Evidence of soreness, ulceration, bleeding gums or whiteness?	Yes	No	If yes, refer to PDS* or advise patient to contact their dentist on discharge
Saliva	Dry mouth? (xerostomia) could be side-effect of medication e.g. antidepressants, anticonvulsants etc.	Yes	No	Offer frequent fluids and/or iced water If symptoms persistent refer to dentist
Teeth	Natural top teeth?	Yes	No	Encourage independence with cleaning teeth night and morning. Use toothbrush and fluoride toothpaste (see Basic Oral Care Guidelines for concentration of fluoride)
	Natural lower teeth?	Yes	No	
	Evidence of plaque / debris?	Yes	No	Supervise/help with oral care Use toothbrush and fluoride toothpaste
Dentures	Top denture?	Yes	No	Supervise/help with cleaning dentures night and morning with mild soap and water; rinse dentures after meals. Clean teeth as above Remove dentures at night and leave to soak in water with Milton
	Lower denture?	Yes	No	
	Dentures and natural teeth?	Yes	No	
Pain	When eating/drinking?	Yes	No	If yes, refer to PDS* or advise patient to contact their dentist on discharge
	Caused by teeth/dentures?	Yes	No	
Swallowing	Difficulty with swallowing?	Yes	No	Supervise/help with cleaning teeth and/or dentures and oral cavity after each meal
Nutrition	NBM / Fluid/dietary intake poor?	Yes	No	May require 2 hourly mouth care Check whether oral problems contributing
	Dehydrated?	Yes	No	
	On energy-dense diet or prescribed supplements/snacks?			Consider high fluoride toothpaste if have natural teeth (2800ppm F)

Signed: .....

Date and Time: .....

* Dental Services Helpline: 01563 507 950

For urgent care or advice on weekdays

NHS 24: 111

For dental emergencies out-of-hours

Risk Assessment

Risk Assessment

Following assessment the Speech and Language Therapist will recommend which texture is suitable for the Individual	
Modified Food Consistency	
Texture B Thin Puree	Smooth consistency with no lumps Can be poured Will slowly drop through prongs of a fork **Thick enough to stand a light plastic teaspoon in**
Texture C Thick Puree	Smooth, moist consistency with no lumps and should not be sticky on palate Cannot be poured Holds its shape on the plate when scooped **No separation of fluids**
Texture D Pre-mashed	Mashed or finely minced before serving Very soft, tender and moist Needs very little chewing **No mixed textures or separation of fluids**
Texture E Fork Mashable	Food must be able to be mashed with a fork Soft, tender and moist Needs some chewing **Meat must be very soft and tender, or minced in thick sauce**

Modified Fluid Consistency	
Stage 1 **Syrup consistency**	Use 1 level scoop of Nutilis Clear in a 200ml drink • This leaves a thin coat on the back of a spoon
Stage 2 **Custard consistency**	Use 2 level scoops of Nutilis Clear in a 200ml drink • This leaves a thick coat on the back of a spoon
Stage 3 **Pudding consistency**	Use 3 level scoops of Nutilis Clear in a 200ml drink • This needs to be taken with a spoon • This will be too thick to drink from a cup

Please record any Therapeutic/Special Diet/Fluids

Texture/Stage/Type (include diabetic, gluten free etc)	Date commenced	Comments	Date discontinued

Please Record if Patient on / Commenced on Supplements
If on supplements please commence supplement monitoring chart

Supplement	Frequency	Any preferences / dislikes	Supplement Chart	On Nutrition Board	Stopped

Any additional interventions (free text)

Further information can be found in the Dietetic Treatment Record

NHS Ayrshire & Arran

Malnutrition Universal Screening Tool ('MUST') Multidisciplinary Care Plan

CHI: 1406650854
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C 28 Redburn Place
S Irvine
F KA12 9BH
A 14/06/1965
Dr TG Miller
MRN: XHI468158
Date of Birth .....

Patient Problem
Nutritional screening has identified the patient as being Low ☒ Medium ☐ High ■ Risk of malnutrition
Patient identified as having other nutritional problems e.g. obesity, chewing certain foods (specify)

Goal
To meet patients nutritional and fluid requirements

Date	Time	Intls	Planned Nursing Interventions/Support	End Date	Intls
21.1.19	1800	JL	**Low Risk Care Plan**		
21.1.19	1800	JL	Assistance required (specify) e.g. helping, prompting, cutting up food, opening packets:-		
21.1.19	1800	JL	Individual / therapeutic dietary requirements (specify) e.g. likes/dislikes religious/ethical/cultural:-		
21.1.19	1800	JL	Modified eating equipment (specify) e.g. cutlery.		
21.1.19	1800	JL	Assist patient to select appropriate meals from menu card.		
21.1.19	1800	JL	Ensure fresh drinking water is offered regularly and available at all times, where clinically appropriate.		
21.1.19	1800	JL	Consider patients positioning and support oral hygiene, if required.		
21.1.19	1800	JL	Ensure patients nutritional needs recorded on nutrition board.		
21.1.19	1800	JL	Monitoring and review care plan **repeat screening weekly** (monthly continuing care).		
			Medium Risk Care Plan (complete low risk section also)		
			Commence food chart for a minimum of 3 days. Only discontinue if/when dietary intake is adequate.		
			If intake is insufficient, offer patient milk to drink with / and between meals and suitable additional snacks.		
			Record accurate fluid intake / output on fluid balance chart until established that oral intake is adequate. If intake per 24 hours is inadequate consider IV/SC fluids.		
			Monitor and review care plan and **repeat screening weekly.**		
			RED TRAY Yes ☐ No ☐ **RED JUG** Yes ☐ No ☐		
			High Risk Care Plan (complete low and medium risk section also)		
			Refer to Dietitian, ensuring the MUST score is included.		
			Discontinue food chart only when advised by Dietitian.		
			Administer and monitor enteral feed via NG/PEG route as per local guidelines.		
			Monitor and review care plan and **repeat screening weekly.**		
21.1.19	1800	JL	This care plan has been discussed and agreed with the patient as appropriate.		

Risk Assessment

MUST Screening

STEP 1
BMI Score

+

STEP 2
Weight Loss Score

+

STEP 3
Acute Disease Effect Score

BMI kg/m²	Score
> 20 (>30) obese)	= 0
18.5 - 20	= 1
< 18.5	= 2

Unplanned weight loss in past 3-6 months	
%	Score
< 5	= 0
5 - 10	= 1
> 10	= 2

If patient is acutely ill **AND** there has been or is likely to be no nutritional intake for > 5 days

SCORE 2

STEP 4
Overall Risk of Malnutrition

Add scores together to calculate overall Risk of Malnutrition

Score 0	Score 1	Score 2 or more
Low Risk		*High Risk*

STEP 5
Nutritional Management Guidelines

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Nutritional Management Guidelines:

MUST Score 0	MUST Score 1	MUST Score 2 or more
Low risk - *Routine Clinical Care*	Medium risk - *Observe*	High risk - *Treat**
• Commence and implement the **Low Risk Care Plan**	• Commence and implement the **Medium Risk Care Plan**	• Commence and implement the **High Risk Care Plan**
• Monitor and review care plan	• Monitor and document dietary intake whilst in ward/department on a Food Record Chart	• Refer to Dietitian, include MUST score
• Repeat screening as below:	• Encourage oral intake	• Continue to monitor dietary intake.
Acute..... weekly	• Assist patient to choose appropriate meals/snacks and offer milk or suitable alternative to drink with and between meals.	• Offer maximum encouragement.
Continuing Care..... monthly	• Provide nutrition information leaflet to patient.	• Monitor and review care plan
	• Monitor and review care plan	• Repeat screening weekly or when next in department.
	• Repeat screening weekly or when next in department.	• Consider use of red tray/jug
		*Unless detrimental or no benefit is expected from nutritional support e.g. imminent death. Use own judgement and document rationale for not treating.

- For low risk patients implement interventions in the **green** section of the care plan, as appropriate.
- For medium risk patients implement interventions in the **green** and sections of the care plan.
- For high risk patients implement interventions in the **green,** and **red** sections of the care plan.
- Always use your own professional judgement when screening patients and making referrals.
- Consider initial admission information relating to eating and drinking needs and preferences.
- When completing Step 2 always compare the most recent weight with the 'usual' weight (or use the initial weight taken on admission if necessary) and not the previous weeks weight.

NHS Ayrshire & Arran

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Nutritional Screening 'Malnutrition Universal Screening Tool' ('MUST')

Food Fluid and Nutrition

Step 1: Measure height and weight to get a BMI score.
Step 2: Note percentage unplanned weight loss and score.
Step 3: Establish acute disease effect and score.
Step 4: Add scores from steps 1, 2 and 3 together to obtain overall risk of malnutrition.
Step 5: Follow the management guidance appropriate to the risk category and commence the corresponding care plan.

Screening Results

Please indicate if measurements are Measured (M), Reported (R) or Estimated (E)

Date	21.1.19	22.1.19			
Time	1800	2350			
Ward	CAU	30.			
Height (metres) (M) (R) (E)	5ft 6 m	5ft6 m			
Current weight (Kg) (M) (R) (E)	111.2 Kg ( )	70.5 Kg ( )	Kg ( )	Kg ( )	Kg ( )
BMI	25	25			
Is patient within obese category?	NO	No			
Usual weight (Kg)	Kg				
Signature					
MUST					
Step 1: BMI Score >20 (>30 = Obese) ..... 0 18.5 - 20 ..... 1 < 18.5 2	0	0			
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months. <5% ..... 0 5 - 10% ..... 1 >10% 2	0	0			
Step 3: Acute Disease Effect Score If patient is acutely ill and there has been or is likely to be no nutritional intake for>5 days.....Score 2 Not applicable .....Score 0	0	0			
Step 4: Overall Risk of Malnutrition Total:	low	low			
Step 5:	0 = Low Risk	1 = Medium Risk	2 or more = High Risk		

Referrals	Consent for referral obtained	Date referred	Signature
Dietician	☐		
Speech and Language Therapy	☐		

Risk Assessment

NHS Ayrshire & Arran

Infection Prevention & Control Assessment

⚠ You MUST CHECK PMS for details where you see this symbol

Complete or attach addressograph

CHI: 1406650854
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MRSA Clinical Risk Assessment (CRA) You MUST CHECK PMS for details where you see this symbol ⚠
ALL PATIENTS MUST HAVE CRA COMPLETE FOR PRE-EMPTIVE ISOLATION PURPOSES

	Yes	No	Action to be taken
Has the patient had any **previous history of MRSA** colonisation or MRSA infection at any time in the past? ⚠ **CHECK PMS**		✓	**After checking PMS ⚠ if you have answered NO to all** three of the questions **then** no further action is required in all non-high risk areas
The patient currently **resident in a care home or institutional setting** (i.e. prison, homeless hostel) or **transferred from another hospital (including those within Ayrshire)?**		✓	**If you have answered 'Yes' to** any of the three questions or your ward is one of the high risk specialties detailed above you **MUST** • Swab **nose and perineum** (& wound or device where applicable) for MRSA
Does the patient **have a wound/ulcer or indwelling medical device** which was present before admission to this hospital?		✓	**If you have answered 'Yes' to any of the three questions regardless of specialty** • Manage patient as if MRSA positive (refer to MRSA Policy) **Date swabs obtained** ..... **Print name**.....

Gastro intestinal risk assessment for CID, norovirus and other gastro-intestinal infections

	Yes	No	Action to be taken
Is the patient presenting at admission with diarrhoeal stool (Bristol stool chart 5, 6, 7) and/or vomiting			If **YES – implement Transmission Based Precautions and isolate patient.** Initiate weekly Bristol stool chart. Send sample to the laboratory. **Date sample sent** ..... **Print name**.....
Has been transferred from any ward/nursing home with suspected or confirmed cases of norovirus.			

Multi drug resistant organism e.g. Carbapenemase-producing Enterobacteriaceae (CPE)

	Yes	No	Action to be taken
Has the patient been • transferred from a hospital outside Scotland • hospitalised outside Scotland in the last 12 months? • Received holiday dialysis outside Scotland • Been a close contact with a person who has been colonised or infected with CPE			**After checking PMS ⚠ if you have answered NO to all** the questions then there is no further action to be taken. If you have answered **YES** to any of the questions you **MUST** screen the patient this includes • Swabs from the **rectum** (& wound or device where applicable) • Manage patient as if CPE positive (refer to CPE Policy) • Inform a member of the Infection Prevention and Control team **NOTE:-IN THE INVESTIGATIONS BOX ON THE LABORATORY REQUEST FORM YOU MUST REQUEST "CPE SCREENING".** **Date swab obtained**..... **Print name**.....
⚠ Has the patient been previously positive for CPE at any body site? **(Check case notes and lab results in addition to PMS)**			

For further advice if required contact the Infection Prevention & Control Team (ext 25765) or the on-call Consultant Microbiologist (via switchboard).

Patient Risk Assessment

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After completing the Individual Person Centred Lifestyle Assessment please now decide which risk assessments your patient needs.

In some circumstances your professional judgement may decide that this patient is exempt from a particular mandatory assessment. You must clearly document the reason for this decision.

Identify relevant assessment tools and tick the box to confirm assessment tool activated.

Yes	N/A		
☑	☐	MRSA	mandatory
☑	☐	Nutrition - MUST	mandatory
☐	☑	Oral Health	initial rapid assessment questions mandatory if clinically indicated
☑	☐	Pressure Area Care - Waterlow	Mandatory if PPURA indicates needs
☑	☐	4AT	all patients over 65 or if patient has a suspected delirium
☐	☐	Bedrails	mandatory
☑	☐	Moving and Handling	mandatory
☐	☐		

You may use your professional judgement to decide which assessment tools are most relevant to your patient. It may not be necessary to complete all risk assessments for every patient.

Not Completed		Reason Why
☐	MRSA	
☐	Nutrition - MUST	
☑	Oral Health	Independant
☐	Pressure Area Care - Waterlow	
☐	Falls	
☐	Bedrails	
☐	Moving and Handling	
☐	4AT	

It will be necessary to re-assess the requirement for completion of the above risk assessments during the patients stay

Nurse Initials: JK Date: 21.1.19

Lifestyle /Assessment

Preliminary Pressure Ulcer Risk Assessment (PPURA)

Complete or attach addressograph

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Dr TG Miller
MRN: XHI468158

Points to consider

- Use within 6 hours of admission to care area
- Use daily if the person is identified to be 'not at risk'
- People who are overweight may not be well nourished
- Please sign after each check

Mobility: Person is fully mobile without equipment/assistance
Continence: Person is fully continent
Nutrition: Person appears well nourished and able to eat and drink
Skin: Persons pressure areas are healthy, with no signs of redness, discolouration, including bruising or ulceration.

Record your answer in the grid below **Y** – Yes or **N** – No
If the answer is **Yes** to all statements use this chart daily
If the answer is **No** to any statement undertake a full pressure ulcer risk assessment and consider any other relevant assessment

Date	Time	Mobility	Continence	Nutrition	Skin inspected	Is a full pressure ulcer risk assessment required?	Signature
21.1.19	1800	Y	Y	Y	N/A		

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Pre Admission Status	Initial assessment
Personal Cleansing & Dressing	**Detail Presenting Problems/Risk/Needs**
Is patient normally independent? Yes ☑ No ☐ What type of assistance is required by the patient (please consider patient preferences)	independent
Skin Condition PPURA	**Detail Presenting Problems/Risk/Needs Preliminary Pressure Ulcer Risk Assessment (PPURA)**
Date 21.1.19 Time 1720 **Mobility** Patient is fully mobile without equipment / assistance Yes ☑ No ☐ **Continence** Patient is fully continent Yes ☑ No ☐ **Nutrition** Patient appears to be well nourished and able to eat and drink Yes ☑ No ☐ **Skin** Skin is healthy and intact Yes ☑ No ☐	Assess condition of skin, any wounds / lesions / stomas If No to any questions undertake Waterlow Assessment and apply the SSKIN bundle if indicated. States skin intact If all answers Yes complete a daily PPURA see page 18
Spiritual or religious needs	**Detail Presenting Problems/Risk/Needs**
Faith or Life Stance? Do you have any spiritual or religious needs whilst in hospital? *(please state)* Yes ☐ No ☑ Do you wish your details passed to the hospital Chaplaincy Service? Yes ☐ No ☑ Do you wish your own Minister/Priest contacted Yes ☐ No ☐ If yes complete name & telephone number Name..... Tel No..... Specify needs or cultural practices that place limitations on the patient's care *(please state)*	

Lifestyle Assessment

Lifestyle Assessment

Lifestyle		Yes	No
Driving Status	Do you Drive	☐	☑
Physical Activity	How many days per week do you usually undertake a total of 30 minutes or more exercise? 0 ☑ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ NA ☐ If less than 5 days, does this equal more than 2½ hours of activity a week	☐	☐
Alcohol Use	Units per week 0 Suitable for alcohol brief intervention? ☑ Not applicable Currently in Treatment? ☐ Not applicable Refer to alcohol liaison team? ☑ Not applicable	☐ ☐ ☐	☐ ☐ ☐
Substance misuse	Substance misuse issues/? If yes give details: Currently in treatment? ☑ Not applicable Refer to substance misuse? ☑ Not applicable	☐ ☐	☐ ☐

Pre Admission Status

Eating and Drinking

Date 21/11/19 Time 1720

Does the patient need assistance in carrying out their own basic oral care? Yes ☐ No ☑

Does the patient have dentures? Yes ☐ No ☑
Top ☐ Bottom ☐ Partial ☐ With Patient ☐

Is the patient suffering from mouth pain? Yes ☐ No ☑

Patient on nutritional supplements / enteral feed at home? Yes ☐ No ☑

Type: _____

Amount _____

Frequency _____ kitchen notified Yes ☐ No ☑

Any changes in eating pattern/appetite? Yes ☐ No ☑

Specify: _____

Support required for eating/drinking? Yes ☐ No ☑

Equipment required to support eating /drinking Yes ☐ No ☑

Likes _____

Dislikes pen's

Long term swallowing ability impaired (Consider referral to SLT) Yes ☐ No ☑

Modified Diet/Fluids Texture..... Stage.....

Consent to therapeutic diet (Cultural/Ethic/Religious requirements) Yes ☐ No ☑

Complete MUST Screening on page 20.

Initial assessment

Detail Presenting Problems/Risk/Needs

NDNF

Eliminating

Normal bowel habit Yes ☐ No ☐

When did your bowels last move? ? last week

Any problems passing urine? Yes ☐ No ☑

Does the patient have a urinary catheter in situ Yes ☐ No ☑

Date of catheter insertion _____

Long term catheter? Yes ☐ No ☑

Complete continence assessment if required

Refer to Adult Continence Assessment Pathway algorithm

Detail Presenting Problems/Risk/Needs

If YES apply the Catheter Care Bundle

Referral Date: _____

Lifestyle Assessment/Usual Ability

Please add date, time & signature when you update the Lifestyle Assessment

Date/time 21.1.19 1720 Sign .....

Date/time..... Sign .....

Date/time..... Sign .....

Write or attach label

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CHI Galloway, Stephen
Surn 28 Redburn Place
Fore Irvine
Addi KA12 9BH
..... 14/06/1965
Date Dr TG Miller
MRN: XHI468158

Pre-admission Status

Communicating

Any specific communication needs:

Speaking	Yes ☐	No ☑
Reading	Yes ☐	No ☑
Writing	Yes ☐	No ☑
Glasses	Yes ☑	No ☐
Contact Lenses	Yes ☐	No ☑

Hearing aid - Left ☐ with Patient ☐

Hearing aid - Right ☐ with Patient ☐

Initial assessment

Detail Presenting Problems/Risk/Needs

Interpreter required** Yes ☐ No ☑

At all times

Breathing

Do you normally have any issues with breathing?

Yes ☐ No ☑

If yes, please describe.....

.....

Equipment / aids - circle all that apply: Inhalers / oxygen -concentrator / cylinder / nebulisers / tracheostomy.

Do you smoke? Yes ☑ No ☐

If so how many..... 15 per day .....

All smokers *must* be referred to Fresh Air-shire for discussion about smoking management whilst in hospital; this will include being advised about the current smoking policy. Please attach a patient sticker to referral card and place it in the Fresh Air-shire referral box on the ward. For any queries please phone Fresh Air-shire on 08007 839132.

Please tick when this referral has been made ☐

Date & time of referral.....

Detail Presenting Problems/Risk/Needs

Patient wishes nicotine replacement therapy?

Yes ☐ No ☑

Should a patient insist on leaving the ward for a cigarette, a smoking disclaimer must be completed.

Smoking disclaimer signed Yes ☐ No ☐

Mobilising/Falls Risk Assessment

Does the patient normally have a reduced functional ability	Yes ☐	No ☑
Walking aids	Yes ☐	No ☑
Pain	Yes ☐	No ☑
Foot Problems	Yes ☐	No ☑
Poor balance	Yes ☐	No ☑
Uncoordinated movements	Yes ☐	No ☑
Medication that could increase risk	Yes ☐	No ☑
Falls History	Yes ☐	No ☑
Cognitive Impairment	Yes ☐	No ☑
Sensory Problems	Yes ☐	No ☑
Is patient at risk of falling from bed?	Yes ☐	No ☑

Detail Presenting Problems/Risk/Needs

Independantly mobile

Denies any falls

Is the patient at risk of falls?* Yes ☐ No ☐

* Consider increasing frequency of care and comfort rounding
* Consider higher level supervision policy
** Language Line 0845 310990 ID No L28656

MDT Discharge Plan

Multi-Disciplinary Discharge Summary

Date & Time	This should include reference to SSA, 24hr continuing care or rehab	Initials

Multi-Disciplinary Discharge Summary

Date & Time	This should include reference to SSA, 24hr continuing care or rehab	Initials

MDT Discharge Plan

	Final checklist Please complete all sections of this checklist on discharge	Yes	No	N/A	Int
	Cannula removed				
	Patients own medication returned				
	Discharge prescription given and explained to patient/carer				
	Clinic follow up arrangements given. (Please record in discharge summary)				
	7-days dressing supply provided				
	Patients property packed and valuables returned				
	If DNACPR keep copy in patients notes and send original home.				
	Send home "Getting to Know Me" document if appropriate				
	Anticipatory Care Pathway or any other relevant community plan/pathway?				
	Inform family/NOK/carer when patient leaves the ward (If appropriate)				
	If appropriate the patient and their carer are provided with the NHS Preventing Pressure Ulcers: A guide for Adults at risk of Pressure Ulcers leaflet.				

Equipment needs; essential equipment should be in place for discharge				
Equipment type	Date Requested	Arranged by	Expected delivery date	Delivery confirmed
Physio (specify)				
OT (specify)				
Commode				
Community electric profiling bed frame				
Pressure Reducing Mattress*				
Chair Cushion				
Foot protectors				
Wheelchair				
Oxygen Cylinder and/or Concentrator				
Enteral Feeding Equipment				
Community alarm				
Key safe				
Other (specify)				

* Please call the district nurse to discuss before ordering.

Multi-Disciplinary Discharge Plan

To ensure safe and timeous discharge planned in partnership with the patient/carer and staff.

PATIENTS SHOULD BE CONSIDERED FOR CRITERIA LED DISCHARGE IF USED APPLY STICKER TO MDT DISCHARGE SUMMARY.

HC CHI: 1406650854
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..... 14/06/1965
Da Dr TG Miller
MRN: XHI468158

Estimated discharge date:..... Medically fit date:..... Ready for discharge: .....

Date & Time	Reason for EDD change	New EDD	Initials

Discharge planning should be commenced on the day of admission

Date		Yes	No	N/A	Int
23/1	Does the patient require a discharge planning meeting?		✓		NS
23/1	If yes to the above contact patient, family, social work and members of the MDT Record date of meeting...../Outcome.....			✓	NS
	Discuss, document and agree discharge plan with patient, relatives, carers and MDT				
23/1	Equipment needed. **Please document on checklist over page.**			✓	NS
	Does the patient have house keys Key safe number:				
23/1	Does the patient have appropriate clothing for discharge	✓			NS
	Does the patient require a **Fit Note**				
	Has the patient been given a **Fit Note**				
23/1	Does the patient require a home visit or environment assessment			✓	NS
	Continuing care at home	Yes	No	N/A	Int
	Referred to ICES ☐ Homecare ☐ Occupational Therapy ☐ Physiotherapy ☐				
	Homecare referral type New referral ☐ Increase ☐ Restart ☐				
	Level of Homecare Package				
	Homecare confirmed by..... Start Date & Time.....				
	Community nurse referral made ☐ Referred to Podiatry ☐				
	Discharge Medication/Aids	Yes	No	N/A	Int
	Order discharge prescription **(Consider Blister pack or MAR chart)**				
	Discharge prescription is on the ward				
	7 day supply of dressing, continence aids, catheters or stoma products (new patients must be given a 7 day supply and refer to district nurse for re-assessment)				
	Nutritional Supplements/Enteral Feed/Thickener: new patients must be given a 7 day supply				
	Transport Those able to make their own travel arrangements should be encouraged to do so	Yes	No	N/A	Int
	Own transport arrangements:				
	Hospital transport booked. Ambulance ☐am ☐pm **Reference No:**				
	Discharge Lounge	Yes	No	N/A	Int
	Is the patient suitable for the discharge lounge (Ext XH 26467 / 8) (Ayr 17078)				
	Plans in place to facilitate morning discharge If no document why				

MDT Discharge Plan

Home Circumstances

Home circumstances on admission

Do you have a carer: Yes ☐ No ☑

If yes: Family ☐ Private ☐

Do you live:-

Alone Yes ☑
With dependent partner ☐
With independent partner / family ☐
Does carer require additional support (Consider referral to social work) ☐

Are you a carer? Yes ☐ No ☐

Who for:
Children ☐ Elderly relative ☐ Other ☐

Please specify: .....

Who is caring for them currently?
Family ☐ Social Worker ☐
Nursing Home ☐ Neighbour ☐
Respite Centre ☐ Other ☐
Please specify:

Describe Family Living Arrangements

Type of House maisonette
Steps at entrance ☑ How many? 40
Stairs inside ☑ How many? 1
Toilet: Upstairs ☑ Downstairs ☐
Bedroom: Upstairs ☑ Downstairs ☐
Banister ☐ Others .....

Comments

Community Services in Use

		Frequency	Informed of Admission	Informed By / Comments
Home Care provided	Yes ☐ No ☑		Yes ☐ No ☐	
Meals on Wheels	Yes ☐ No ☑		Yes ☐ No ☐	
Sheltered Housing	Yes ☐ No ☑		Yes ☐ No ☐	
Day Hospital	Yes ☐ No ☑		Yes ☐ No ☐	
Community Nurse	Yes ☐ No ☑		Yes ☐ No ☐	
Community Psychiatric Nurse	Yes ☐ No ☑		Yes ☐ No ☐	
Learning Disability Nurse	Yes ☐ No ☑		Yes ☐ No ☐	
Visited by Specialist Nurse	Yes ☐ No ☑		Yes ☐ No ☐	
Specify:			Yes ☐ No ☐	

Functional Assessment of Medication Use: Complete for all patients

Pre-Admission Status
Independent ☑ Prompting required ☐ Assistance required ☐
Level ..... MAR Chart ☐ Compliance aid ☐ .....

On Admission Initial Assessment
Independent ☐ Prompting required ☐ Assistance required ☐
Level ..... MAR Chart ☐ Compliance aid ☐ .....

Do community nurses assist in medicine administration? Yes ☐ No ☑

If Yes, please provide details e.g. insulin administration .....

Nurse Initials: ..... Date: 21.1.19
Nurse Initials: ..... Date: .....
Nurse Initials: ..... Date: .....
Nurse Initials: ..... Date: .....

Remember to re-assess patient needs and service requirements pre-discharge

Person-centred care is where the patient is an equal partner with the health or care professional and where both parties work together to make an assessment, identify options for and the delivery of the most appropriate care. The care provided is holistic and the 'whole person' sits at the centre of the care package, which may be delivered by a range of health and social care professionals.

To promote person-centred care our focus is changing from asking 'What's the matter with you' to asking 'What matters to you'. We can do this by reliably covering the five 'Must do with me' elements of care with patients and/or their families and carers. This will help to ensure all of the interactions between people using our services and the staff delivering them are person-centred and are characterised by listening, dignity, compassion and respect.

5 Must do's. These can be answered by patient/family/carers

What is important or matters to you?

What are the most important things for you that we can help you with/ do for you while you are here? e.g; *'that my wife/husband can be present when the consultant talks to me'; 'that I can choose my meal rather than someone else choosing it for me'; 'that my pet has been taken care of'; 'that my medication is given at the right time';*

.....

.....

.....

.....

Who matters to you?

Who are the most important people to you and how would you like them involved in your care? eg. family, friend, chaplain, minister, priest.

.....

.....

.....

.....

What information do you need?

eg when will the doctor see me'; 'visiting times'; 'meal times'; 'Can I smoke'; 'can I get out of the bed'; 'can I wear outdoor clothes in the ward'; 'what is the name of my nurse'; 'what can and can't I do'; 'how to contact relatives'; 'if mobiles can be used'; 'how to use Hospedia;'

.....

.....

.....

.....

Do you require any assistance to understand information e.g. Family / other Yes ☐ No ☐

Leaflets / written: Yes ☐ No ☐

Personalised Contact

As much as possible, try to be flexible about the timing of interventions to meet the patients personal needs. *Example questions of this could be, Would it be ok if we check on you every 1-2 hours to check you are ok or if you need anything?* .....

.....

.....

Nothing about you without you

Whilst you are in the ward we will involve you in any decisions regarding your care and discuss any referrals with you.

Nurse Initials ..... Date .....

Personal Details

Personal Details

Adult Support and Protection – 3 point criteria

An adult who:

- Are unable to safeguard their own well-being, property, rights or other interests
- Are at risk of harm; and
- Because they are affected by disability, mental disorder, illness or physical or mental infirmity are more vulnerable to being harmed than adults who are not so affected.

Harm includes:

- All harmful conduct and in particular:
- Conduct which causes physical harm;
- Conduct which causes psychological harm (for example by causing fear, alarm or distress);
- Financial harm
- Conduct which causes self-harm

If you have a concern about an adult who you believe is or may be at risk of harm complete an ASP/Concern referral.

ASP / Concern referral submitted Yes ☐ No ☑

All referral information can be found on AthenA Adult Support and Protection site.

Consent to display limited information

Patient consents to display of CHI number and limited personal information about care (e.g. bedrails, diet, mobility, "forget me not") on a chart at the bedside and whiteboard etc.

Consent given: Yes ☑ No ☐ By whom: Patient ☑ Relative/Carer ☐

If the patient has declined to consent to information being displayed at the bed space please provide information here .....

.....

Nurse Initials ..JK.. Date 21.1.19

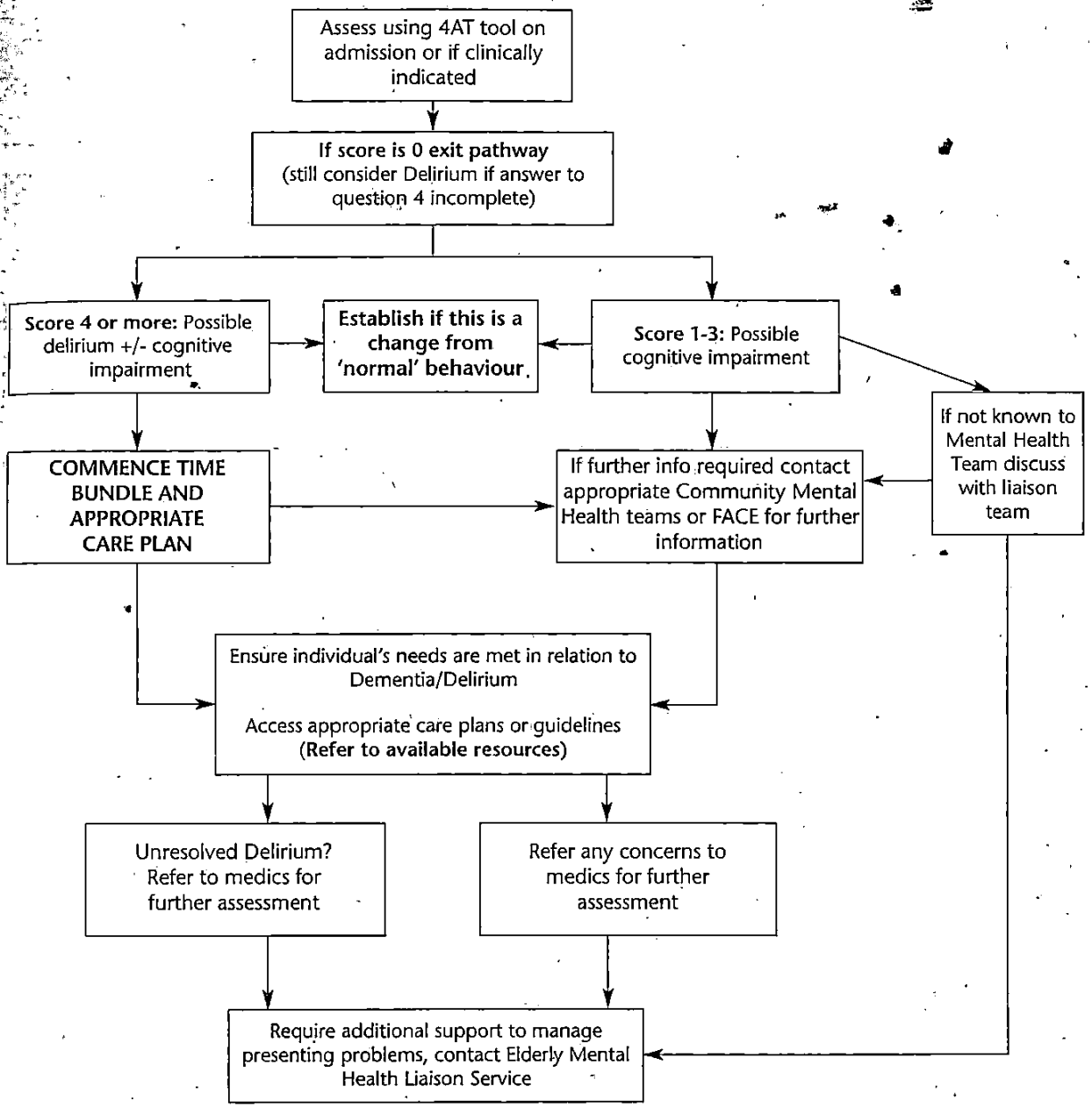
Useful Contacts:

To support your plan of care for this patient you might find it helpful to contact the relevant liaison service below:

Learning Disability Liaison Nurse Specialist:	01294 323560 (north) 01292 614910 (south) 01563 578574 (east)
Mental Health Liaison Nurses (Elderly Services)	01292 513007
Psychiatric Liaison Nurse (Adult general hospitals)	01563 826120
Advocacy Services	01294 608664 (north) 01292 264396 (south) 01563 574442 (east)
Hospital Social work team	Hospital site contacts through switchboard.

Additional relevant information (including details of the relevant liaison service contacted)

Nursing Assessment and Management of Cognitive Impairment



Personal Details

Useful Contact numbers

If patient has diagnosis of dementia and lives:
Nursing/Care Home: Contact **Elderly Mental Health Care Home Liaison Nurse** who will be able to provide background information regarding patient and support discharge arrangements.

Telephone no:.....

At home: Contact **Community Mental Health Team** as patient likely to be known to them>they may offer advice and/or background info.

Telephone no:.....

If patient does not have a diagnosis of dementia but further advice/support req'd whilst an in-patient, contact: Elderly Mental Health Liaison service

Telephone no:.....

If patient is known to any of the Mental Health Teams please inform when fit for home/discharge plans.

Useful Available Resources

Access if available:

Getting to Know Me - hand held document used by patients

Dementia Care Plan - for pts with a diagnosis of dementia

Delirium Care Plan - for pts displaying symptoms indicative of delirium

Identification and Management of Delirium in the Elderly - can be found on back of Delirium Care Plan

Behavioural and Psychological Symptoms associated with Dementia - a guide to cause and management in behaviour that challenges in delivery of care of patients with dementia

Abbey Pain Scale - pain tool that should be used for pts with dementia and/or who cannot verbalise

Time Bundle - Time Bundle for patients with 4AT of 4 or more

All of the above resources can be accessed through Athena or in Dementia Resource Folder if available.

Personal Details

Cognitive assessment

To be completed on all patients over 65 or if appropriate or if the patient has suspected delirium
Ask the patient the following questions: (4AT) N/A

	Circle		
	1st Assessment	Further Assessment	Further Assessment
	Date	Date	Date
1. ALERTNESS This includes patients who may be markedly drowsy (eg. Difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gently touch on shoulder. Ask the patient to state their name and address to assist rating			
Normal (fully alert), but not agitated, throughout assessment)	0	0	0
Mild sleepiness for <10 seconds after waking, then normal	0	0	0
Clearly abnormal	4	4	4
2. AMT4 Age, date of birth, place (name of the hospital or building), current year.			
No mistakes	0	0	0
1 mistake	1	1	1
2 or more mistakes/untestable	2	2	2
3. ATTENTION Ask the patient "Please tell me the months of the year in backwards order, starting at December". To assist initial understanding one prompt of "what is the month before December?' is permitted.			
Months of the year backwards, Achieves 7 months or more correctly	0	0	0
Starts but scores <7 months / refuses to start	1	1	1
Untestable (cannot start because unwell, drowsy, inattentive)	2	2	2
4. ACUTE CHANGE OF FLUCTUATING COURSE Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. Paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs			
No	0	0	0
Yes	4	4	4
4 or above: possible delirium +/-cognitive impairment: refer to algorithm			
1-3: possible cognitive impairment			
0: delirium or cognitive impairment unlikely (but delirium still possible if question 4 information incomplete)			
If 4AT of 4 or above commence Time Bundle			
4AT SCORE			
SIGN			

If you have concerns regarding capacity, please refer to algorithm and dementia/delirium care plan.
If no 4AT carried out please document reason eg Patient unconscious.....

Informed Consent and Capacity

While undertaking the patient's clinical assessment, if you have any concerns regarding the patient's capacity and ability to make healthcare decisions refer to medical staff for **assessment and treatment plan** under the Adults With Incapacity (Scotland) Act 2000 and document your actions within the nursing notes. Refer to the Consent policy for further guidance.

Information about the patient can be obtained from relatives and carers including legal guardians (e.g. guardianship through the social work department)

Relatives and carers cannot make decisions for patients except in certain circumstances where they hold Welfare Guardianship or Power of Attorney extending to health care decisions under the Adults With Incapacity (Scotland) Act 2000.

	Yes	No			Names
Advanced Statement	☐	☐			.....
Power of Attorney details	☐	☐	Financial ☐	Welfare ☐	.....
Guardianship details	☐	☐	Financial ☐	Welfare ☐	.....
"Getting to know me" in use	☐	☐			.....

If yes to any of the above obtain a copy of the relevant document.
If diagnosis of dementia is confirmed please ensure appropriate documentation / care plans are initiated

Previous medical, surgical and mental health history

Details	Date (if Known)	Details	Date (if Known)
Anxiety			
Depp			
HTN			
AICD			

Medications

Any important information regarding medications.....

Own medication retained on ward Yes ☐ No ☑ Where stored.....

Have the medications been returned to relatives? Yes ☐ No ☑ ☐ N/A

Please complete below when patient is admitted or transferred to your clinical area

	Ward: CAU		Ward:		Ward:	
Verbal information given to patient and / or relatives:	Date: 21/7/19		Date:		Date:	
	Yes	N/A	Yes	N/A	Yes	N/A
Call buzzer If patients unable to use buzzer ensure this is reflected in care planning	✓					
Toilets / Bathroom	✓					
Explained Protected Mealtimes	✓					
Visiting times	✓					
Hand hygiene	✓					
Valuables	✓					
Smoking	✓					
Patient Discharge Booklet given	✓					
Other						
Sign						

Patient's Property - Where possible send belongings home with family

You are asked to keep belongings/valuables to a minimum whilst in hospital. You are responsible for property belonging to you not handed over for safe custody. This includes cash, spectacles, hearing aids, dentures and other personal items and valuables. Valuables should be sent home at first opportunity or given to the nurse if this is not possible.

Valuables handed over for safe keeping will be sent to the cashier's office and a receipt will be issued. If patient lacks capacity please ensure relevant documentation is completed for belongings and valuables.

Signature of Patient / Significant Other: [signature] Date 21.7.19

Property handed over for Safe Keeping: Yes ☐ No ☑ Sticker on front page: Yes ☐ No ☑

Date taken to Cashier:_____ Cash & Valuables Ref No:_____ Date Returned:_____

Personal Details

supervision	appropriate) if requirement for supervision changes please document on reverse in the evaluation section.
Initials	AH EMC
Designation	RMA

ONLY to be completed if required following assessment - Please record N/A if any aspects of the SSKIN bundle is not relevant to the patient (i.e. patient does not require a cushion or heel protectors) ALL aspects of the bundle must be completed at every bundle completion

3. SSKIN BUNDLE

Frequency of bundle completion: 1hrly 2hrly 4hrly 6hrly 8hrly 12hrly (please circle, if frequency changes please document change in date row, above relevant column and in evaluation)

Date		
Time – using 24-hour clock (record actual time completed)		
Surface – tick when checked (tick if equipment is in use and working-remember mattress alone will not protect heels)		
Mattress appropriate (Please state mattress type)	Y = Appropriate O = Ordered	
Cushion/heel protector appropriate (Please state).....		
Skin Inspection – tick when pressure areas checked – record N if no damage present, R for redness, D for discolouration U for pressure ulcer or E for excoriation/moisture. Record any damage in evaluation below - state where and give description.		
All pressure areas checked (top to toe-**only** tick when done)		
Redness/discolouration/pressure ulcer present		
Tick if skin protection applied (state)		
Keep moving – tick which position patient been repositioned to when encouraged/assisted to move		
BED	Right side (30° tilt)	
	Left side (30° tilt)	
	Back	
	Sliding sheet required	
	Independent	
CHAIR		
Incontinence – tick if patient incontinent of urine/faeces or both		
Urine (Specify Pad and pants if in use)		
Bowels		
Nutrition –Ensure where appropriate food record chart, fluid balance and supplement recording sheet used. Document current diet using the appropriate code – ND =Normal Diet / ED = Energy Dense / MC = Modified Consistency / NBM = Nil by Mouth / EF = Enteral feeding - **If diet changes enter change alongside date of change**		
Diet:		
Initials		
Designation		

Documentation codes

✓ - When care / action is given / completed **Re** – refused **A** - asleep **V** - variance – record on evaluation sheet on page 2

N/A – not applicable

CARE & COMFORT ROUND incorporating Falls and SSKIN bundles

NHS Ayrshire & Arran

It is not necessary to write in every box every time a care and comfort round is undertaken, only complete as required using the codes above

1. CARE & COMFORT ROUND

Frequency of rounding: 1hrly 2hrly 4hrly 6hrly (please circle, if frequency changes please document change in date row, above relevant column and in evaluation)

Date	21/1																								
Time – using 24-hour clock (record actual time completed)	21 30	05 30	89 30																						
Orientate to time & place as appropriate and encourage opportunity to express needs	✓	✓	✓																						
Assess pain & ensure patient is comfortable (If Pain present - Commence pain chart and action)	✓		✓																						
Encourage/support oral diet & fluids where appropriate	✓																								
Offer assistance to visit toilet/any other continence needs	N/A		I																						
Assist with personal hygiene as required: **BB**-bed bath **IB**-immersion bath **BW**-basin wash **SH**-shower	NA		N D.																						
Offer assistance with oral care	NA																								
Provide assurance that you will return in a timescale	✓	✓																							
Initials	AF	[illegible]	PMC																						
Designation	SN		N/A																						

ONLY to be completed if the patient triggers on the falls for all bundle (see in patient profile) and all patients in older peoples' wards Please record N/A if any aspects of the falls bundle is not relevant to the patient (i.e. patient does not require walking aid, footwear or glasses or unable to use their call bell)
ALL aspects of the bundle must be completed at every bundle completion

2. VULNREABLE FALLS BUNDLE

Frequency of bundle completion: 1hrly 2hrly 4hrly 6hrly 8hrly 12hrly (please circle, if frequency changes please document change in date row, above relevant column and in evaluation)

Date																									
Time – using 24-hour clock (record actual time completed)	05 30	89 30																							
Environment is clear of clutter & well lit	✓																								
Call buzzer in reach & working	✓	1																							
Appropriate footwear available & in use	✓	2																							
If glasses & hearing aid worn, they are available & in use		D																							
Provision of walking aid as required & is within reach Please circle: Walking stick / Zimmer frame / Other.....	✓	✓																							
Chair & bed consistently at best height for individual, to enable safe transfers																									
DAILY assessment of the requirement for higher level	Higher level supervision required Yes / No - If Yes - Cohort Nursing or 1-1 Nursing (please circle as																								

| | | |

CARE & CO[illegible] ORT ROUND incorporating Falls and SSI[illegible] bundles

NHS Ayrshire & Arran

Documentation codes

✓ - When care / action is given / completed **Re** – refused **A** - asleep **V** - variance – record on evaluation sheet on page 2

N/A – not applicable

It is not necessary to write in every box every time a care and comfort round is undertaken, only complete as required using the codes above

1. CARE & COMFORT ROUND

Frequency of rounding: 1hrly 2hrly 4hrly 6hrly (please circle, if frequency changes please document change in date row, above relevant column and in evaluation)

Date 6/11/18	6/11																										
Time – using 24-hour clock (record actual time completed)	16 30	18 30	2050																								
Orientate to time & place as appropriate and encourage opportunity to express needs	✓	✓	✓																								
Assess pain & ensure patient is comfortable (If Pain present - Commence pain chart and action)	✓	✓	✓																								
Encourage/support oral diet & fluids where appropriate	✓	✓	✓																								
Offer assistance to visit toilet/any other continence needs																											
Assist with personal hygiene as required: **BB**-bed bath **IB**-immersion bath **BW**-basin wash **SH**-shower																											
Offer assistance with oral care	✓	✓	✓																								
Provide assurance that you will return in a timescale	✓	✓	✓																								
Initials	KwC	KwC	JM																								
Designation	MA	MA	SN																								

ONLY to be completed if the patient triggers on the falls for all bundle (see in patient profile) and all patients in older peoples' wards. Please record N/A if any aspects of the falls bundle is not relevant to the patient (i.e. patient does not require walking aid, footwear or glasses or unable to use their call bell)
ALL aspects of the bundle must be completed at every bundle completion

2. VULNREABLE FALLS BUNDLE

Frequency of bundle completion: 1hrly 2hrly 4hrly 6hrly 8hrly 12hrly (please circle, if frequency changes please document change in date row, above relevant column and in evaluation)

Date 6/11/18	6/11																										
Time – using 24-hour clock (record actual time completed)	16 30	18 30																									
Environment is clear of clutter & well lit	✓	✓																									
Call buzzer in reach & working	✓	✓																									
Appropriate footwear available & in use	✓	✓																									
If glasses & hearing aid worn, they are available & in use	✓	✓																									
Provision of walking aid as required & is within reach Please circle: Walking stick / Zimmer frame / Other.....	NA																										
Chair & bed consistently at best height for individual, to enable safe transfers		✓																									

Full V assessment of the requirement for higher levels — Higher level supervision required- Yes / No - If Yes - Cohort Nursing or 1-1 Nursing (please circle as

supervision.	appropriate) if requirement for supervision changes please document on reverse in the evaluation section.
Initials	
Designation	

ONLY to be completed if required following assessment - Please record N/A if any aspects of the SSKIN bundle is not relevant to the patient (i.e. patient does not require a cushion or heel protectors) ALL aspects of the bundle must be completed at every bundle completion

3. SSKIN BUNDLE

Frequency of bundle completion: 1hrly 2hrly 4hrly 6hrly 8hrly 12hrly (please circle, if frequency changes please document change in date row, above relevant column and in evaluation)

Date		
Time – using 24-hour clock (record actual time completed)		
Surface – tick when checked (tick if equipment is in use and working-remember mattress alone will not protect heels)		
Mattress appropriate (Please state mattress type)	Y = Appropriate O = Ordered	
Cushion/heel protector appropriate (Please state).....		
Skin Inspection – tick when pressure areas checked – record N if no damage present, R for redness, D for discolouration U for pressure ulcer or E for excoriation/moisture. Record any damage in evaluation below - state where and give description.		
All pressure areas checked (top to toe-**only** tick when done)		
Redness/discolouration/pressure ulcer present		
Tick if skin protection applied (state)		
Keep moving – tick which position patient been repositioned to when encouraged/assisted to move		
BED Right side (30° tilt)		
Left side (30° tilt)		
Back		
Sliding sheet required		
Independent		
CHAIR		
Incontinence – tick if patient incontinent of urine/faeces or both		
Urine (Specify Pad and pants if in use)		
Bowels		
Nutrition – Ensure where appropriate food record chart, fluid balance and supplement recording sheet used. Document current diet using the appropriate code – ND = Normal Diet / ED = Energy Dense / MC = Modified Consistency / NBM = Nil by Mouth / EF = Enteral feeding - **If diet changes enter change alongside date of change**		
Diet:		
Initials		
Designation		

Documentation codes
✓ - When care / action is given / completed **Re** – refused **A** - asleep **V** - variance – record on evaluation sheet on page 2
N/A – not applicable

CARE & COMFORT ROUND incorporating Falls and Skin bundles

NHS Ayrshire & Arran

It is not necessary to write in every box every time a care and comfort round is undertaken, only complete as required using the codes above

1. CARE & COMFORT ROUND

Frequency of rounding: 1hrly 2hrly 4hrly 6hrly (please circle, if frequency changes please document change in date row above relevant column and in evaluation)

Date 2018	04/11	04/11			5/11				05/11	05/11	05/11	05/11	05/11	05/11	05/11	06/11	06/11	06/11	06/11				
Time – using 24-hour clock (record actual time completed)	15 40	17 45	20 00	23 00	02 00	05 00	08 00	08 00	09 30	11 30	13 30	15 30	18 20	20 40	22 00	00 00	02 30	04 00	05 30	07 00	08 30	10 30	12 30	14 30
Orientate to time & place as appropriate and encourage opportunity to express needs	✓	✓	✓	✓					✓	✓	✓	✓	✓	✓	✓	A	A	A	A	✓	✓	✓	✓	✓
Assess pain & ensure patient is comfortable (If Pain present - Commence pain chart and action)	✓	✓	✓	✓	A	A	A	A	✓	✓	✓	✓	✓	✓	✓	A	A	A	A	✓	✓	✓	✓	✓
Encourage/support oral diet & fluids where appropriate	✓	✓	✓	✓					✓	✓	✓	✓	✓	✓	✓	A	A	A	A	✓	✓	✓	✓	✓
Offer assistance to visit toilet/any other continence needs														NA	NA	NA	NA	NA	NA	NA				
Assist with personal hygiene as required: **BB**-bed bath **IB**-immersion bath **BW**-basin wash **SH**-shower														NA	NA	NA	NA	NA	NA	NA				
Offer assistance with oral care														NA	NA	NA	NA	NA	NA	NA				
Provide assurance that you will return in a timescale	✓	✓	✓	✓	A	A	A	A	✓	✓	✓	✓	✓	✓	✓	A	A	A	A	A	✓	✓	✓	✓
Initials	DW	JW	TD	TD	TD	TD	TD	TD	DW	DW	DW	DW	DW	CH	CH	CH	CH	CH	CH	CH	kmc	kmc	kmc	kmc
Designation	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

ONLY to be completed if the patient triggers on the falls for all bundle (see in patient profile) and all patients in older peoples' wards. Please record N/A if any aspects of the falls bundle is not relevant to the patient (i.e. patient does not require walking aid, footwear or glasses or unable to use their call bell)
ALL aspects of the bundle must be completed at every bundle completion.

2. VULNREABLE FALLS BUNDLE

Frequency of bundle completion: 1hrly 2hrly 4hrly 6hrly 8hrly 12hrly (please circle, if frequency changes please document change in date row, above relevant column and in evaluation)

Date 2018	04/11	04/11												05/11	05/11	06/11	06/11	06/11	06/11				
Time – using 24-hour clock (record actual time completed)	15 40	17 45	20 00											20 40	22 00	00 00	02 30	04 00	05 30	07 00	08 30	10 30	12 30	14 30
Environment is clear of clutter & well lit	✓	✓	✓											✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Call buzzer in reach & working	✓	✓	✓											✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Appropriate footwear available & in use	✓	✓	✓											✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
If glasses & hearing aid worn, they are available & in use														✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Provision of walking aid as required & is within reach Please circle: Walking stick / Zimmer frame / Other.....														NA	NA	NA	NA	NA	NA	NA				
Chair & bed consistently at best height for individual, to enable safe transfers														✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
DAILY assessment of the requirement for higher level	Higher level supervision required Yes / No - If Yes - Cohort Nursing or 1-1 Nursing (please circle as																							

NHS
Ayrshire & Arran

Ayrshire Assessment and Management of Alcohol Withdrawal Syndrome (AAMAWS)

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158
.....DOB:.....

STEP 1: DETERMINE ALCOHOL HISTORY (to be completed by the prescriber)

Estimated Weekly Alcohol Units: _____ (Daily Units x 7 days)
excessive weekly consumption (♂& ♀ >14 units/week)
Estimated day/time of last drink: 04-11-18 (if > 5 days, re-consider alcohol withdrawal status)

Presents with (or previous history) Alcohol Related Seizure **Yes** ☐ **No** ☐

Presents with (or previous history) Delirium Tremens **Yes** ☐ **No** ☐

Number of Units = ABV (%) x Volume (litres) e.g.

A bottle of wine (750mls) which is 12% ABV = 12 x 0.75 = 9 Units
A glass of wine (200mls) which is 12% ABV = 12 x 0.2 = 2.4 Units

ALCOHOL SCREENING TOOL *("Audit PC")*

	SCORE					
	0	**1**	**2**	**3**	**4**	**Total**
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times a week	4 or more times a week	3
2. How many **units of alcohol** do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	4
3. How often during the last year have you found that you were not able to stop drinking once you had started	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	0
4. How often during the last year have you failed to do what was normally expected of you because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	1
5. Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes but not in the past year		Yes during the past year	4
TOTAL SCORE:						12

0-5:Responsible drinking pattern **6-10:Hazardous drinking pattern**
11-14:Harmful drinking pattern **15-20:Dependent drinking pattern**
If Audit PC score indicates that the individual is drinking at harmful / hazardous / dependent levels referral to be made to Alcohol liaison.

STEP 2: DETERMINE TREATMENT OPTION FOR THE MANAGEMENT OF ALCOHOL WITHDRAWAL SYNDROME (to be completed by the prescriber)

RISK OF SEVERE ALCOHOL WITHDRAWAL

Any 2 of the following:

- Presents with or has had previous withdrawal seizures ☐
- Previous episode of Delirium Tremens ☐
- Clinically has alcohol dependence / scoring 15 or above on Alcohol ScreeningTool *Audit PC* (see step 1 above) ☐
- High initial symptom score (GMAWS > 8) ☐ (Do not use scoring tool if patient intoxicated or < 8 hours since last drink)

YES → FIXED DOSE TREATMENT **(AAMAWS) PLUS** SYMPTOM TRIGGERED TREATMENT **(GMAWS – standard or reduced dose diazepam or lorazepam)**

NO → SYMPTOM TRIGGERED TREATMENT **(GMAWS – standard or reduced dose diazepam or lorazepam)**

SELECT TREATMENT OPTION:

NO TREATMENT ☐ **GMAWS only** ☐ **GMAWS PLUS FIXED DOSE (AAMAWS)** ☐

Treatment must be prescribed on HEPMA and GMAWS prescription chart overleaf

NOTE! Fixed dose & symptom triggered dosing must be no less than 1 hour apart

NHS
Ayrshire
& Arran

PRESCRIBING GUIDANCE

DOSE EQUIVALENCE

APPROXIMATE ORAL BENZODIAZEPINE EQUIVALENCE: 10mg diazepam = 1mg lorazepam

ORAL to IM / IV BENZODIAZEPINE DOSE EQUIVALENCE: IM / IV benzodiazepine dose equivalent is half the oral dose

Example: patient requires diazepam 20mg four times per day orally
Equivalent dose of IM / IV diazepam would be 10mg four times per day
Equivalent dose of oral lorazepam would be 2mg four times per day
Equivalent dose of IM/IV lorazepam would be 1mg four times per day

EXCEPTIONAL PATIENT GROUPS:

- Actual or suspected head injury
- Hepatic impairment (patients with elevated Bilirubin or Prothrombin Time who are at risk of benzodiazepine accumulation)
- Other co-morbidities where the patient is at risk of over-sedation on respiratory depression e.g Respiratory or cerebrovascular disease, reduced Glasgow Coma Scale

Consider the use of oral Lorazepam in these exceptional patient groups in a symptom triggered fashion: dose should be based on the patient's GMAWS score.

ELDERLY PATIENTS (>65 years) +/OR PATIENTS WITH CrCl <20 ml/min:

In general *half the dose of benzodiazepines* is usually recommended (the need for this is dependent on overall fitness, co-morbidity and degree of frailty). To minimise adverse effects associated with benzodiazepines (e.g. over sedation, confusion and ataxia) it is important to bear in mind the *start low and go-slow* rule in these patient groups (start with lower doses, monitor frequently and increase if necessary as symptoms suggest).

PATIENTS UNABLE TO TOLERATE ORAL MEDICATION

Patients unable to tolerate oral medication may receive intravenous therapy as an alternative at **50% the oral dose** in the first instance, and response assessed. Please consider benzodiazepine dose equivalences (see above).

MONITORING

All patients should be closely observed for signs of over-sedation with regular observations. Exceptional Patient Groups (see above), patients with Severe Withdrawal and patients requiring Intravenous or Intramuscular Sedation require close monitoring (NEWS). Please refer to the NHS Ayrshire & Arran Clinical Guideline G078 for further information on the care of patients requiring a Higher Level of Supervision in Acute Hospital Settings.

PABRINEX ADMINISTRATION

Please refer to ADTC 92 In-patient Guideline for treatment of Thiamine Deficiency in patients with Chronic Alcohol misuse using Pabrinex® Injection. Patients at risk or with suspected of Wernicke's Encephalopathy should be prescribed high dose parenteral Pabrinex® 2 pairs three times daily intravenously for 3-5 days or until clinical improvement ceases.

DISCHARGE PLANNING

Patients should not be routinely discharged until detox process is complete.

NHS Ayrshire & Arran

Fluid and Low Risk Infusion Therapy Recording Chart

Ward/Department ....CAU / AMBULATORY CARE....

Consultant .....WILLIAMS.....

Write or attach label

HCR No: .....

CHI No: ...1406650354.....

Surname: ...CATHCART.....

Forename: ...STEVEN..... Sex (M)

Address: ...28 KILBURN PLACE.....

.....

Date of Birth: 14/06/65.....

		Fluid (use block letters) Electrolyte addictive 3	Vol (ml) Mmols 4	Route of Admin 5	Duration Rate 6	Pump Yes/No 7	Mon Time every (hrs / mins) 8	Signatures 9	Batch Nos 10	Given by Added by 11	Start Time 12
A	21/1/19	(N) saline	500	IV	40	YES			181ST31D exp 08/21	1 Litre bag	UM/ 223
B	21/1/19	(N) saline	500	IV	60	YES					
C											
D											
E											
F											
G											
H											
I											
J											
K											
L											

Use this chart of infusions of Fluids, Electrolytes (less than 40 mmol per litre potassium chloride), Blood, Blood Products and T.P.N.
If a volumetric pump is used the monitoring section on the reverse must be completed.

RS 5925

If a volumetric pump is used for any infusion on the previous page, the infusion ID should be noted on the chart below and the monitoring details completed at intervals specified by the prescriber of the infusion.

The **INFUSION CHECKS** box should be ticked to indicate that the following checks have been made: **Pump Rate, Infusion site, Vol. remaining in bag is approx. as expected, patient's condition.**

INF I.D. 1	Vol. Pump Make 2	Serial Number 3	Date 4	Time 5	Vol. Fused (from pump) 6	Infusion Checks 7	Signed 8

NHS Ayrshire & Arran

Fluid and Low Risk Infusion Therapy Recording Chart

Ward/Department .....

Consultant .....

Write or attach label
HCR No: A066505F
CHI No: Galloway
Surname: Stephen
Forename: ..... Sex .....
Address: .....
.....
Date of Birth: .....

		Fluid (use block letters) Electrolyte addictive 3	Vol (ml) Mmols 4	Route of Admin 5	Duration Rate 6	Pump Yes/No 7	Mon Time every (hrs / mins) 8	Signatures 9	Batch Nos 10	Given by Added by 11	Start Time 12
A	4/11	(N) SALINE	1000	IV	STAT						1540.
B	4/11	HARTMANNS	1000	IV	4°						1730.
C	4/11	(K) SALINE	500	IV	6°				18F 23F 24F	MA	2000
D											
E											
F											
G											
H											
I											
J											
K											
L											

Use this chart of infusions of Fluids, Electrolytes (less than 40 mmol per litre potassium chloride), Blood, Blood Products and T.P.N.
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INF I.D. 1	Vol. Pump Make 2	Serial Number 3	Date 4	Time 5	Vol. Fused (from pump) 6	Infusion Checks 7	Signed 8

NHS Ayrshire & Arran

Ayrshire Assessment and Management of Alcohol Withdrawal Syndrome (AAMAWS)

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158
DOB:

STEP 1: DETERMINE ALCOHOL HISTORY (to be completed by the prescriber)

Estimated Weekly Alcohol Units: _____ (Daily Units x 7 days)
excessive weekly consumption (♂& ♀ >14 units/week)
Estimated day/time of last drink: _____ (if > 5 days, re-consider alcohol withdrawal status)
Presents with (or previous history) Alcohol Related Seizure Yes ☑ No ☑
Presents with (or previous history) Delirium Tremens Yes ☑ No ☐

Number of Units = ABV (%) x Volume (litres) e.g.

A bottle of wine (750mls) which is 12% ABV = 12 x 0.75 = 9 Units
A glass of wine (200mls) which is 12% ABV = 12 x 0.2 = 2.4 Units

ALCOHOL SCREENING TOOL *("Audit PC")*

	SCORE					
	0	1	2	3	4	Total
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times a week	4 or more times a week	
2. How many **units of alcohol** do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more ✓	
3. How often during the last year have you found that you were not able to stop drinking once you had started	Never	Less than monthly	Monthly	Weekly	Daily or almost daily ✓	
4. How often during the last year have you failed to do what was normally expected of you because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily ✓	
5. Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes but not in the past year		Yes during the past year ✓	
TOTAL SCORE:						20

0-5:Responsible drinking pattern **6-10:Hazardous drinking pattern**
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RISK OF SEVERE ALCOHOL WITHDRAWAL

Any 2 of the following:

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- Previous episode of Delirium Tremens ☑
- Clinically has alcohol dependence / scoring 15 or above on Alcohol ScreeningTool *Audit PC* (see step 1 above) ☑
- High initial symptom score (GMAWS > 8) ☐
  (Do not use scoring tool if patient intoxicated or < 8 hours since last drink) ✗

YES → FIXED DOSE TREATMENT **(AAMAWS)** **PLUS** SYMPTOM TRIGGERED TREATMENT **(GMAWS – standard or reduced dose diazepam or lorazepam)**

NO → SYMPTOM TRIGGERED TREATMENT **(GMAWS – standard or reduced dose diazepam or lorazepam)**

SELECT TREATMENT OPTION

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NHS
Ayrshire
& Arran

PRESCRIBING GUIDANCE

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DISCHARGE PLANNING

Patients should not be routinely discharged until detox process is complete.

Our purpose

Working together to achieve the healthiest life possible for everyone in Ayrshire and Arran

NHS Ayrshire & Arran

CHI: 1406650854
Name: Galloway, Stephen
28 Redburn Place
CHI Nu Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

PATIENT PROFILE

Please complete below when patient is admitted or transferred to your clinical area

	Admission		Transfer 1		Transfer 2		Transfer 3	
Hospital	XH							
Ward	CAU							
Consultant	Dr Manuel							
Date / Time	4/11/18	1400						
Relative Informed	(Yes)	No	Yes	No	Yes	No	Yes	No
ID Band in situ	(Yes)	No	Yes	No	Yes	No	Yes	No
Completed By - Signature								

The Patient Profile can be used for patients with ongoing regular treatment i.e. for a course of therapy or weekly blood transfusion, however if there is a gap of more than 6 weeks since last attendance repeat lifestyle assessment (p15).

If the patient is readmitted into UHC or UHA an additional MRSA/CRA (p20) must be completed. Additional forms can be obtained from the infection control AthenA site.

This profile can also be used for readmission within 3 days.
Please remember to review earlier risk assessments.

Property handed over for safe keeping

PLACE VALUABLES STICKER HERE

Our values

Caring Safe Respectful

Clinical Team Signatures

All staff completing the documentation **must** complete this section

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

Name (BLOCK CAPS)	Profession	Ward/ Page No	Signature	Initials
C.BROWN	SN	CAU	CB	CB
M.BUNN	RN	CAU		
K MULLER	SN	ACAU	KMuller	KM
A. WAMAN	SN	CAU	Lmall	KL

Abbreviations

This abbreviation list has been approved for use by NHS Ayrshire & Arran

ANP	Advanced Nurse Practitioner	ICES	Intermediate Care and Enablement Services
ABG	Arterial Blood Gas	ICU	Intensive Care Unit
BM	Blood Glucose Monitoring	IM	Intramuscular
BMI	Body Mass Index	INR	International Normalised Ratio
BO	Bowels Open	IV	Intravenous
BP	Blood Pressure	LFTs	Liver Function Tests
CABG	Coronary Artery Bypass Graft	L+S BP	Lying and Standing Blood Pressure
CAU	Combined Assessment Unit	MAR	Medication Administration Record
CCU	Coronary Care Unit	MEWS	Modified Early Warning Score
CDI	Clostridium Difficile Infection	MHC	Medical High Care
CDU	Clinical Decisions Unit	MI	Myocardial Infarction
CHI	Community Health Index	MRI	Magnetic Resonance Imaging
CKD	Chronic Kidney Disease	MRSA	Methicillin Resistant Staphylococcus Aureus
CLD	Criteria Led Discharge	MSSU	Mid Stream Specimen of Urine
CLDT	Community Learning Disability Team	MUST	Malnutrition Universal Screening Tool
COPD	Chronic Obstructive Pulmonary Disease	NAD	No Abnormalities Detected
CPR	Cardio Pulmonary Resuscitation	NBM	Nil By Mouth
CRP	C - Reactive Protein	NG	Nasogastric
CSU	Catheter Specimen of Urine	NOF	Neck of Femur
CSW	Clinical Support Worker	O2	Oxygen
CT	Computerised Tomography	OT	Occupational Therapist
CVC	Central Venous Catheter	PEG	Percutaneous Endoscopic Gastrostomy
DOB	Date of Birth	PICC	Peripherally Inserted Central Catheter
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation	PMH	Past Medical History
ECG	Electrocardiogram	PN	Parental Nutrition
ED	Emergency Department	PVC	Peripheral Vascular Catheter
EDD	Estimated Date of Discharge	SP02	Saturation of Peripheral Oxygen
ERCP	Endoscopic Retrograde Cholangiopancreatography	SBAR	Situation Background Assessment Recommendations
ERT	Emergency Response Team	SC	Subcutaneous
ESBL	Extended Spectrum Beta Lactamase	SLT	Speech and Language Therapy
ESR	Erythrocyte Sedementation Ratio	TFTs	Thyroid Function Tests
FBC	Full Blood Count	USS	Ultra Sound Scan
GP	General Practitioner	U&Es	Urea and Electrolytes
H@N	Hospital at Night	UTI	Urinary Tract Infection
HAI	Healthcare Associated Infection	WCC	White Cell Count
HDU	High Dependency Unit	WZF	Wheeled Zimmer Frame

Personal Details

Personal Details

Prefers to be known as:	Age:
Stephen	53
Receiving Consultant:	Allocated Consultant:
From where:	Accompanied by:
Emergency ☐ Elective ☐	Patients telephone number:
	Patients mobile number: 07468337186

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

GP Name:
GP Address:

Reason for Admission

Abdo pain
Alcohol withdrawal

Patients Account of Reason for Admission

Vomitting yesterday (bloody) + diarrhoea

Drinks 1-1.5L spirits/day

Next of Kin/First contact/Significant other

Name: John Thompson
Address:

Relationship to patient: Neighbour
Contact No(s) Home:
Mobile:
Aware of admission Yes ☐ No ☐
Contact overnight Yes ☐ No ☐

Consent to share information with significant other listed: Yes ☐ No ☐

Second contact/significant other

Name:
Address:

Relationship to patient:
Contact No(s) Home:
Mobile:
Aware of admission Yes ☐ No ☐
Contact overnight Yes ☐ No ☐

Specific Alerts

Previous known MRSA Yes ☐ No ☑
Ensure risk assessment completed

Clostridium Difficile Yes ☐ No ☑
ESBL Yes ☐ No ☑
Other infectious conditions? Yes ☐ No ☑
Specify:

Specific Alerts

Drug Allergies:

Other allergies (food, latex, etc)

None known ☑

Observation on admission		+ ++ +++ ++++		+ ++ +++		+ ++ +++ ++++		+ ++ +++		-ve +ve
Urinalysis	NAD ☐	Protein	Trace	Blood	Trace	Glucose	Trace	Leucocytes	Trace	Nitrates
MSSU collected?				Yes ☐		No ☐		Date.....		

Glucometer Reading: Yes ☐ No ☐
Result:.....

Date Last Menstrual Period (if appropriate)

Pregnancy Test (if appropriate) +ve ☐ -ve ☐

Pain Score	low						severe				
	0	1	2	3	4	5	6	7	8	9	10

For patients with cognitive impairment please refer to Abbey pain scale

Previous medical, surgical and mental health history

Details	Date (if Known)	Details	Date (if Known)
Alcohol Withdrawal.			
(+ seizures 2° alc-withdrawal)			

Medications

Any important information regarding medications.....

Own medication retained on ward Yes ☐ No ☐ Where stored.....

Have the medications been returned to relatives? Yes ☐ No ☐ ☐ N/A

Please complete below when patient is admitted or transferred to your clinical area

	Ward: CAU		Ward:		Ward:	
Verbal information given to patient and / or relatives:	Date: 4/11/18		Date:		Date:	
	Yes	N/A	Yes	N/A	Yes	N/A
Call buzzer If patients unable to use buzzer ensure this is reflected in care planning	✓					
Toilets / Bathroom	✓					
Explained Protected Mealtimes	✓					
Visiting times	✓					
Hand hygiene	✓					
Valuables	✓					
Smoking		✓				
Patient Discharge Booklet given		✓				
Other						
Sign	CB.					

Patient's Property - Where possible send belongings home with family

You are asked to keep belongings/valuables to a minimum whilst in hospital. You are responsible for property belonging to you not handed over for safe custody. This includes cash, spectacles, hearing aids, dentures and other personal items and valuables. Valuables should be sent home at first opportunity or given to the nurse if this is not possible.

Valuables handed over for safe keeping will be sent to the cashier's office and a receipt will be issued. If patient lacks capacity please ensure relevant documentation is completed for belongings and valuables.

Signature of Patient / Significant Other: ✱ Date.....

Property handed over for Safe Keeping: Yes ☐ No ☐ Sticker on front page: Yes ☐ No ☐

Date taken to Cashier:..... Cash & Valuables Ref No:..... Date Returned:.....

Personal Details

Personal Details

Cognitive assessment

To be completed on all patients over 65 or if appropriate or if the patient has suspected delirium
Ask the patient the following questions: (4AT)

	Circle		
	1st Assessment	Further Assessment	Further Assessment
	Date	Date	Date
1. ALERTNESS This includes patients who may be markedly drowsy (eg. Difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gently touch on shoulder. Ask the patient to state their name and address to assist rating			
Normal (fully alert), but not agitated, throughout assessment)	0	0	0
Mild sleepiness for <10 seconds after waking, then normal	0	0	0
Clearly abnormal	4	4	4
2. AMT4 Age, date of birth, place (name of the hospital or building), current year.			
No mistakes	0	0	0
1 mistake	1	1	1
2 or more mistakes/untestable	2	2	2
3. ATTENTION Ask the patient "Please tell me the months of the year in backwards order, starting at December". To assist initial understanding one prompt of "what is the month before December?' is permitted.			
Months of the year backwards, Achieves 7 months or more correctly	0	0	0
Starts but scores <7 months / refuses to start.	1	1	1
Untestable (cannot start because unwell, drowsy, inattentive)	2	2	2
4. ACUTE CHANGE OF FLUCTUATING COURSE Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. Paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs			
No	0	0	0
Yes	4	4	4
4 or above: possible delirium +/-cognitive impairment: refer to algorithm			
1-3: possible cognitive impairment			
0: delirium or cognitive impairment unlikely (but delirium still possible if question 4 information incomplete)			
If 4AT of 4 or above commence Time Bundle			
4AT SCORE			
SIGN			

If you have concerns regarding capacity, please refer to algorithm and dementia/delirium care plan.

If no 4AT carried out please document reason eg Patient unconscious.....

Informed Consent and Capacity

While undertaking the patient's clinical assessment, if you have any concerns regarding the patient's capacity and ability to make healthcare decisions refer to medical staff for **assessment and treatment plan** under the Adults With Incapacity (Scotland) Act 2000 and document your actions within the nursing notes. Refer to the Consent policy for further guidance.

Information about the patient can be obtained from relatives and carers including legal guardians (e.g. guardianship through the social work department)

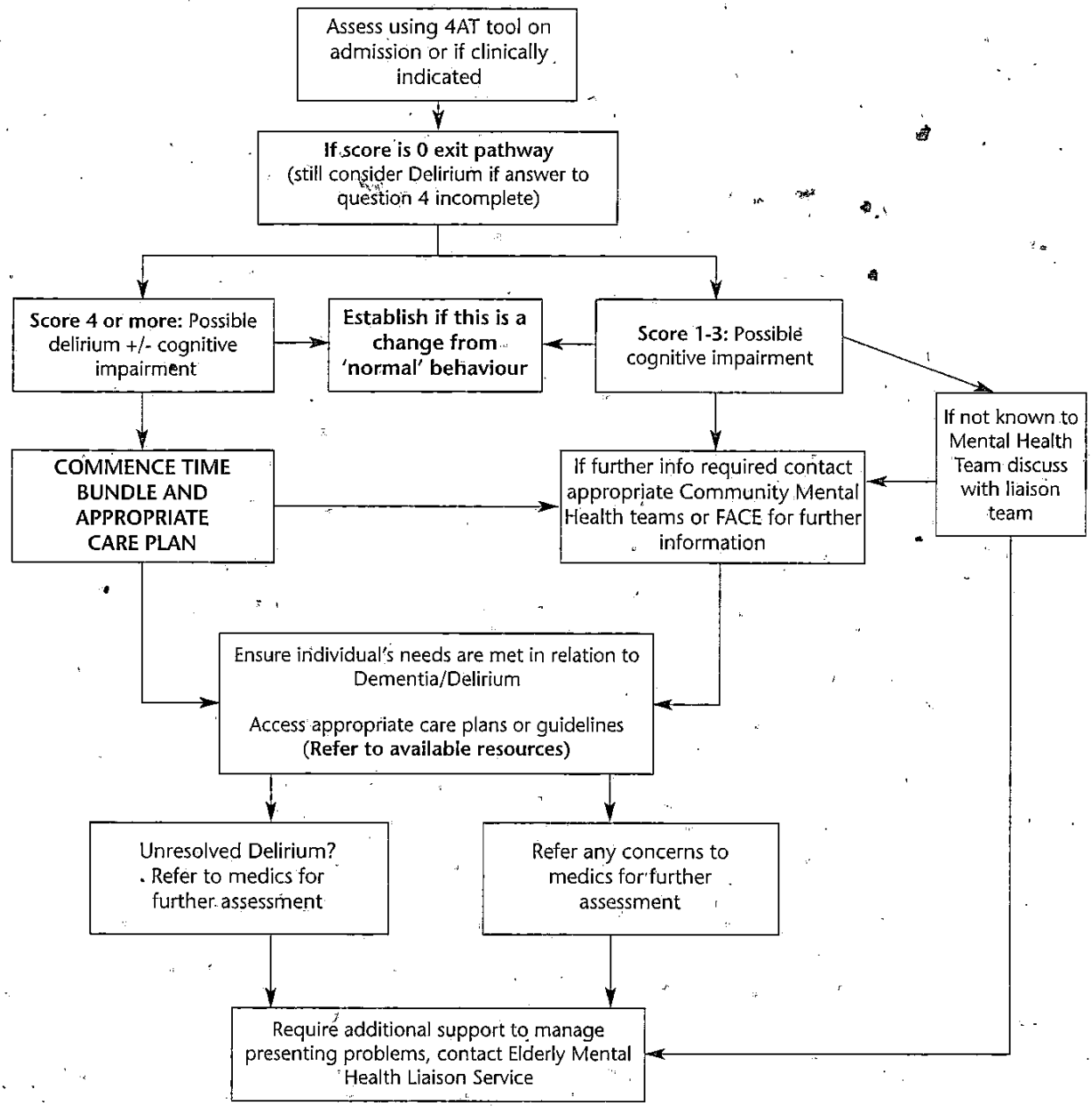
Relatives and carers cannot make decisions for patients except in certain circumstances where they hold Welfare Guardianship or Power of Attorney extending to health care decisions under the Adults With Incapacity (Scotland) Act 2000.

	Yes	No			Names
Advanced Statement	☐	☐			.....
Power of Attorney details	☐	☐	Financial ☐	Welfare ☐	.....
Guardianship details	☐	☐	Financial ☐	Welfare ☐	.....
"Getting to know me" in use	☐	☐			.....

If yes to any of the above obtain a copy of the relevant document.

If diagnosis of dementia is confirmed please ensure appropriate documentation / care plans are initiated

Nursing Assessment and Management of Cognitive Impairment



Useful Contact numbers

If patient has diagnosis of dementia and lives:
Nursing/Care Home: Contact **Elderly Mental Health Care Home Liaison Nurse** who will be able to provide background information regarding patient and support discharge arrangements.

Telephone no:.....

At home: Contact **Community Mental Health Team** as patient likely to be known to them>they may offer advice and/or background info.

Telephone no:.....

If patient does not have a diagnosis of dementia but further advice/support req'd whilst an in-patient, contact: **Elderly Mental Health Liaison service**

Telephone no:.....

If patient is known to any of the Mental Health Teams please inform when fit for home/discharge plans.

Useful Available Resources

Access if available:

Getting to Know Me - hand held document used by patients

Dementia Care Plan - for pts with a diagnosis of dementia

Delirium Care Plan - for pts displaying symptoms indicative of delirium

Identification and Management of Delirium in the Elderly - can be found on back of Delirium Care Plan

Behavioural and Psychological Symptoms associated with Dementia - a guide to cause and management in behaviour that challenges in delivery of care of patients with dementia

Abbey Pain Scale - pain tool that should be used for pts with dementia and/or who cannot verbalise

Time Bundle - Time Bundle for patients with 4AT of 4 or more –

All of the above resources can be accessed through Athena or in Dementia Resource Folder if available.

Personal Details

Personal Details

Adult Support and Protection – 3 point criteria

An adult who:

- Are unable to safeguard their own well-being, property, rights or other interests
- Are at risk of harm; and
- Because they are affected by disability, mental disorder, illness or physical or mental infirmity are more vulnerable to being harmed than adults who are not so affected.

Harm includes:

- All harmful conduct and in particular:
- Conduct which causes physical harm;
- Conduct which causes psychological harm (for example by causing fear, alarm or distress);
- Financial harm
- Conduct which causes self-harm

If you have a concern about an adult who you believe is or may be at risk of harm complete an ASP/Concern referral.

ASP / Concern referral submitted Yes ☐ No ☐

All referral information can be found on AthenA Adult Support and Protection site.

Consent to display limited information

Patient consents to display of CHI number and limited personal information about care (e.g. bedrails, diet, mobility, "forget me not") on a chart at the bedside and whiteboard etc.

Consent given: Yes ☑ No ☐ By whom: Patient ☑ Relative/Carer ☐

If the patient has declined to consent to information being displayed at the bed space please provide information here .....

.....

Nurse Initials ..... Date 6/11/18

Useful Contacts:

To support your plan of care for this patient you might find it helpful to contact the relevant liaison service below:

Learning Disability Liaison Nurse Specialist:	01294 323560 (north) 01292 614910 (south) 01563 578574 (east)
Mental Health Liaison Nurses (Elderly Services)	01292 513007
Psychiatric Liaison Nurse (Adult general hospitals)	01563 826120
Advocacy Services	01294 608664 (north) 01292 264396 (south) 01563 574442 (east)
Hospital Social work team	Hospital site contacts through switchboard.

Additional relevant information (including details of the relevant liaison service contacted)

Person-centred care is where the patient is an equal partner with the health or care professional and where both parties work together to make an assessment, identify options for and the delivery of the most appropriate care. The care provided is holistic and the 'whole person' sits at the centre of the care package, which may be delivered by a range of health and social care professionals.

To promote person-centred care our focus is changing from asking 'What's the matter with you' to asking 'What matters to you'. We can do this by reliably covering the five 'Must do with me' elements of care with patients and/or their families and carers. This will help to ensure all of the interactions between people using our services and the staff delivering them are person-centred and are characterised by listening, dignity, compassion and respect.

5 Must do's. These can be answered by patient/family/carers

What is important or matters to you?

What are the most important things for you that we can help you with/ do for you while you are here? e.g; *'that my wife/husband can be present when the consultant talks to me'; 'that I can choose my meal rather than someone else choosing it for me'; 'that my pet has been taken care of'; 'that my medication is given at the right time';*

.....

.....

.....

.....

Who matters to you?

Who are the most important people to you and how would you like them involved in your care? eg. family, friend, chaplain, minister, priest.

.....

.....

.....

.....

What information do you need?

eg when will the doctor see me'; 'visiting times'; 'meal times'; 'Can I smoke'; 'can I get out of the bed'; 'can I wear outdoor clothes in the ward'; 'what is the name of my nurse'; 'what can and can't I do'; 'how to contact relatives'; 'if mobiles can be used'; 'how to use Hospedia;'

.....

.....

.....

.....

Do you require any assistance to understand information e.g. Family / other Yes ☐ No ☐

Leaflets / written: Yes ☐ No ☐

Personalised Contact

As much as possible, try to be flexible about the timing of interventions to meet the patients personal needs. *Example questions of this could be, Would it be ok if we check on you every 1-2 hours to check you are ok or if you need anything?* .....

.....

.....

Nothing about you without you

Whilst you are in the ward we will involve you in any decisions regarding your care and discuss any referrals with you.

Nurse Initials ..... Date .....

Personal Details

Home Circumstances

Home circumstances on admission

Do you have a carer: Yes ☐ No ☑
If yes: Family ☐ Private ☐
Do you live:-
Alone Yes ☑
With dependent partner ☐
With independent partner / family ☐
Does carer require additional support (Consider referral to social work) ☐
Are you a carer? Yes ☐ No ☑
Who for:
Children ☐ Elderly relative ☐ Other ☐
Please specify: .....
Who is caring for them currently?
Family ☐ Social Worker ☐
Nursing Home ☐ Neighbour ☐
Respite Centre ☐ Other ☐
Please specify:

Describe Family Living Arrangements

Type of House .....
Steps at entrance ☐ How many? .....
Stairs inside ☐ How many? .....
Toilet: Upstairs ☐ Downstairs ☐
Bedroom: Upstairs ☑ Downstairs ☐
Banister ☐ Others .....
.....

Comments

Community Services in Use		Frequency	Informed of Admission	Informed By / Comments
Home Care provided	Yes ☐ No ☑		Yes ☐ No ☐	
Meals on Wheels	Yes ☐ No ☑		Yes ☐ No ☐	
Sheltered Housing	Yes ☐ No ☑		Yes ☐ No ☐	
Day Hospital	Yes ☐ No ☑		Yes ☐ No ☐	
Community Nurse	Yes ☐ No ☑		Yes ☐ No ☐	
Community Psychiatric Nurse	Yes ☐ No ☑		Yes ☐ No ☐	
Learning Disability Nurse	Yes ☐ No ☐		Yes ☐ No ☐	
Visited by Specialist Nurse	Yes ☐ No ☑		Yes ☐ No ☐	

Specify:

Functional Assessment of Medication Use: **Complete for all patients**

Pre-Admission Status		
Independent ☑	Prompting required ☐	Assistance required ☐
Level ..... MAR Chart ☐	Compliance aid ☐	.....
On Admission Initial Assessment		
Independent ☑	Prompting required ☐	Assistance required ☐
Level ..... MAR Chart ☐	Compliance aid ☐	.....

Do community nurses assist in medicine administration? Yes ☐ No ☐
If Yes, please provide details e.g. insulin administration .....
.....

Nurse Initials: CB Date: 4/11/18
Nurse Initials: ..... Date: .....
Nurse Initials: ..... Date: .....
Nurse Initials: ..... Date: .....

Remember to re-assess patient needs and service requirements pre-discharge

Multi-Disciplinary Discharge Plan

To ensure safe and timeous discharge planned in partnership with the patient/carer and staff.

PATIENTS SHOULD BE CONSIDERED FOR CRITERIA LED DISCHARGE IF USED APPLY STICKER TO MDT DISCHARGE SUMMARY.

Write or attach label

HCR No:.....
CHI No:.....
Surname:.....
Forename:..... Sex:.....
Address:.....
.....
Date of Birth.....

Estimated discharge date:..... Medically fit date:..... Ready for discharge: .....

Date & Time	Reason for EDD change	New EDD	Initials

Discharge planning should be commenced on the day of admission

Date		Yes	No	N/A	Int
	Does the patient require a discharge planning meeting?				
	If yes to the above contact patient, family, social work and members of the MDT Record date of meeting...../Outcome.....				
	Discuss, document and agree discharge plan with patient, relatives, carers and MDT				
	Equipment needed. **Please document on checklist over page.**				
	Does the patient have house keys Key safe number:				
	Does the patient have appropriate clothing for discharge				
	Does the patient require a **Fit Note**				
	Has the patient been given a **Fit Note**				
	Does the patient require a home visit or environment assessment				
	Continuing care at home	Yes	No	N/A	Int
	Referred to ICES ☐ Homecare ☐ Occupational Therapy ☐ Physiotherapy ☐				
	Homecare referral type New referral ☐ Increase ☐ Restart ☐				
	Level of Homecare Package				
	Homecare confirmed by..... Start Date & Time.....				
	Community nurse referral made ☐ Referred to Podiatry ☐				
	Discharge Medication/Aids	Yes	No	N/A	Int
	Order discharge prescription **(Consider Blister pack or MAR chart)**				
	Discharge prescription is on the ward				
	7 day supply of dressing, continence aids, catheters or stoma products (new patients must be given a 7 day supply and refer to district nurse for re-assessment)				
	Nutritional Supplements/Enteral Feed/Thickener: new patients must be given a 7 day supply				
	Transport Those able to make their own travel arrangements should be encouraged to do so	Yes	No	N/A	Int
	Own transport arrangements:				
	Hospital transport booked. Ambulance ☐ am ☐ pm **Reference No:**				
	Discharge Lounge	Yes	No	N/A	Int
	Is the patient suitable for the discharge lounge (Ext XH 26467 / 8) (Ayr 17078)				
	Plans in place to facilitate morning discharge **If no document why**				

MDT Discharge Plan

	Final checklist Please complete all sections of this checklist on discharge	Yes	No	N/A	Int
	Cannula removed				
	Patients own medication returned				
	Discharge prescription given and explained to patient/carer				
	Clinic follow up arrangements given. (Please record in discharge summary)				
	7-days dressing supply provided				
	Patients property packed and valuables returned				
	If DNACPR keep copy in patients notes and send original home				
	Send home "Getting to Know Me" document if appropriate				
	Anticipatory Care Pathway or any other relevant community plan/pathway?				
	Inform family/NOK/carer when patient leaves the ward (If appropriate)				
	If appropriate the patient and their carer are provided with the NHS Preventing Pressure Ulcers: A guide for Adults at risk of Pressure Ulcers leaflet.				

Equipment needs; essential equipment should be in place for discharge				
Equipment type	Date Requested	Arranged by	Expected delivery date	Delivery confirmed
Physio (specify)				
OT (specify)				
Commode				
Community electric profiling bed frame				
Pressure Reducing Mattress*				
Chair Cushion				
Foot protectors				
Wheelchair				
Oxygen Cylinder and/or Concentrator				
Enteral Feeding Equipment				
Community alarm				
Key safe				
Other (specify)				

* Please call the district nurse to discuss before ordering.

Multi-Disciplinary Discharge Summary

Date & Time	This should include reference to SSA, 24hr continuing care or rehab	Initials

MDT Discharge Plan

MDT Discharge Plan

Multi-Disciplinary Discharge Summary

Date & Time	This should include reference to SSA, 24hr continuing care or rehab	Initials

Lifestyle Assessment/Usual Ability

Please add date, time & signature when you update the Lifestyle Assessment

Date/time 4/11/18 Sign

Date/time Sign

Date/time Sign

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Dr TG Miller
MRN: XHI468158

Pre-admission Status
Communicating

Any specific communication needs:

Speaking	Yes ☐	No ☑
Reading	Yes ☐	No ☑
Writing	Yes ☐	No ☑
Glasses	Yes ☐	No ☑
Contact Lenses	Yes ☐	No ☑

Hearing aid - Left ☐ with Patient ☐
Hearing aid - Right ☐ with Patient ☐

Initial assessment
Detail Presenting Problems/Risk/Needs

Interpreter required** Yes ☐ No ☑

Breathing

Do you normally have any issues with breathing?
Yes ☐ No ☑
If yes, please describe.....

Equipment / aids - circle all that apply: Inhalers / oxygen -concentrator / cylinder / nebulisers / tracheostomy.

Do you smoke? Yes ☑ No ☐
If so how many 15 per day

All smokers ***must*** be referred to Fresh Air-shire for discussion about smoking management whilst in hospital; this will include being advised about the current smoking policy. Please attach a patient sticker to referral card and place it in the Fresh Air-shire referral box on the ward. For any queries please phone Fresh Air-shire on 08007 839132.

Please tick when this referral has been made ☑

Date & time of referral 4/11/18

Detail Presenting Problems/Risk/Needs

Patient wishes nicotine replacement therapy?
Yes ☐ No ☑

Should a patient insist on leaving the ward for a cigarette, a smoking disclaimer must be completed.

Smoking disclaimer signed Yes ☐ No ☑

Mobilising/Falls Risk Assessment

Does the patient normally have a reduced functional ability	Yes ☐	No ☑
Walking aids	Yes ☐	No ☑
Pain	Yes ☐	No ☑
Foot Problems	Yes ☐	No ☑
Poor balance	Yes ☐	No ☑
Uncoordinated movements	Yes ☐	No ☑
Medication that could increase risk	Yes ☐	No ☑
Falls History	Yes ☐	No ☑
Cognitive Impairment	Yes ☐	No ☑
Sensory Problems	Yes ☐	No ☑
Is patient at risk of falling from bed?	Yes ☐	No ☑

Detail Presenting Problems/Risk/Needs

Is the patient at risk of falls?* Yes ☐ No ☑

* Consider increasing frequency of care and comfort rounding
* Consider higher level supervision policy
** Language Line 0845 310990 ID No L28656

Lifestyle Assessment

Lifestyle Assessment

Lifestyle		Yes	No
Driving Status	Do you Drive	☐	☑
Physical Activity	How many days per week do you usually undertake a total of 30 minutes or more exercise? 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ NA☑ If less than 5 days, does this equal more than 2½ hours of activity a week	☐	☐
Alcohol Use	Units per week 1.5L per day spirits Suitable for alcohol brief intervention? ☐ Not applicable Currently in Treatment? ☐ Not applicable Refer to alcohol liaison team? ☐ Not applicable	☐ ☐ ☐	☐ ☐ ☐
Substance misuse	Substance misuse issues/? If yes give details: Currently in treatment? ☑ Not applicable Refer to substance misuse? ☑ Not applicable	☐ ☐ ☐	☐ ☐ ☐

Pre Admission Status

Eating and Drinking

Date..... Time .....

Does the patient need assistance in carrying out their own basic oral care? Yes☐ No☑

Does the patient have dentures? Yes☐ No☑
Top☐ Bottom☐ Partial☐ With Patient☐

Is the patient suffering from mouth pain? Yes☐ No☑

Patient on nutritional supplements / enteral feed at home? Yes☐ No☑

Type: _____

Amount _____ kitchen notified Yes☐ No☐

Frequency _____

Any changes in eating pattern/appetite? Yes☐ No☑

Specify: _____

Support required for eating/drinking? Yes☐ No☑

Equipment required to support eating /drinking Yes☐ No☑

Likes _____

Dislikes _____

Long term swallowing ability impaired (Consider referral to SLT) Yes☐ No☑

Modified Diet/Fluids Texture..... Stage.....

Consent to therapeutic diet (Cultural/Ethic/Religious requirements) Yes☐ No☑

Complete MUST Screening on page 20.

Eliminating

Normal bowel habit Yes☑ No☐

When did your bowels last move? .....

Any problems passing urine? Yes☐ No☑

Does the patient have a urinary catheter in situ Yes☐ No☑

Date of catheter insertion _____

Long term catheter? Yes☐ No☑

Complete continence assessment if required

Refer to Adult Continence Assessment Pathway algorithm

Initial assessment

Detail Presenting Problems/Risk/Needs

NDTNF

Detail Presenting Problems/Risk/Needs

If YES apply the Catheter Care Bundle

Referral Date: _____

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Pre Admission Status	Initial assessment
Personal Cleansing & Dressing	**Detail Presenting Problems/Risk/Needs**
Is patient normally independent? Yes ☑ No ☐ What type of assistance is required by the patient (please consider patient preferences)	
Skin Condition PPURA	**Detail Presenting Problems/Risk/Needs Preliminary Pressure Ulcer Risk Assessment (PPURA)**
Date 4/11/18 Time 1500. **Mobility** Patient is fully mobile without equipment / assistance Yes ☑ No ☐ **Continence** Patient is fully continent Yes ☑ No ☐ **Nutrition** Patient appears to be well nourished and able to eat and drink Yes ☑ No ☐ **Skin** Skin is healthy and intact Yes ☑ No ☐	Assess condition of skin, any wounds / lesions / stomas Pt states skins intact. If No to any questions undertake Waterlow Assessment and apply the SSKIN bundle if indicated. If all answers Yes complete a daily PPURA see page 18
Spiritual or religious needs	**Detail Presenting Problems/Risk/Needs**
Faith or Life Stance? Do you have any spiritual or religious needs whilst in hospital? *(please state)* Yes ☐ No ☑ Do you wish your details passed to the hospital Chaplaincy Service? Yes ☐ No ☑ Do you wish your own Minister/Priest contacted Yes ☐ No ☑ If yes complete name & telephone number Name..... Tel No..... Specify needs or cultural practices that place limitations on the patient's care *(please state)*	

Lifestyle Assessment

Preliminary Pressure Ulcer Risk Assessment (PPURA)

Haemoglobin
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Points to consider

- Use within 6 hours of admission to care area
- Use daily if the person is identified to be 'not at risk'
- People who are overweight may not be well nourished
- Please sign after each check

Mobility:	Person is fully mobile without equipment/assistance
Continence:	Person is fully continent
Nutrition:	Person appears well nourished and able to eat and drink
Skin:	Persons pressure areas are healthy, with no signs of redness, discolouration, including bruising or ulceration.

Record your answer in the grid below **Y** – Yes or **N** – No
If the answer is **Yes** to all statements use this chart daily
If the answer is **No** to any statement undertake a full pressure ulcer risk assessment and consider any other relevant assessment

Date	Time	Mobility	Continence	Nutrition	Skin inspected	Is a full pressure ulcer risk assessment required?	Signati
4/11/18	1410	Y	Y	Y	Y	NO	

Patient Risk Assessment

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After completing the Individual Person Centred Lifestyle Assessment please now decide which risk assessments your patient needs.

In some circumstances your professional judgement may decide that this patient is exempt from a particular mandatory assessment. You must clearly document the reason for this decision.

Identify relevant assessment tools and tick the box to confirm assessment tool activated.

Yes	N/A		
☑	☐	MRSA	mandatory
☑	☐	Nutrition - MUST	mandatory
☐	☑	Oral Health	initial rapid assessment questions mandatory if clinically indicated
☐	☑	Pressure Area Care - Waterlow	Mandatory if PPURA indicates needs
☐	☑	4AT	all patients over 65 or if patient has a suspected delirium
☑	☐	Bedrails	mandatory
☑	☐	Moving and Handling	mandatory
☐	☐		

You may use your professional judgement to decide which assessment tools are most relevant to your patient. It may not be necessary to complete all risk assessments for every patient.

Not Completed		Reason Why
☐	MRSA	
☐	Nutrition - MUST	
☑	Oral Health	NOT CLINICALLY INDICATED
☑	Pressure Area Care - Waterlow	
☑	Falls	
☐	Bedrails	
☐	Moving and Handling	
☐	4AT	

It will be necessary to re-assess the requirement for completion of the above risk assessments during the patients stay

Nurse Initials: CB Date: 4/11/18

Risk Assessment

Risk Assessment

NHS Ayrshire & Arran

Infection Prevention & Control Assessment

⚠ You MUST CHECK PMS for details where you see this symbol

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MRSA Clinical Risk Assessment (CRA) You MUST CHECK PMS for details where you see this symbol ⚠
ALL PATIENTS MUST HAVE CRA COMPLETE FOR PRE-EMPTIVE ISOLATION PURPOSES

	Yes	No	Action to be taken
Has the patient had any **previous history of MRSA** colonisation or MRSA infection at any time in the past? ⚠ **CHECK PMS**		✓	**After checking PMS ⚠ if you have answered NO to all** three of the questions **then** no further action is required in all non-high risk areas
The patient currently **resident in a care home or institutional setting** (i.e. prison, homeless hostel) or **transferred from another hospital (including those within Ayrshire)?**		✓	**If you have answered 'Yes' to any** of the three questions or your ward is one of the high risk specialties detailed above you **MUST** • Swab **nose and perineum** (& wound or device where applicable) for MRSA
Does the patient **have a wound/ulcer or indwelling medical device** which was present before admission to this hospital?		✓	**If you have answered 'Yes' to any of the three questions regardless of specialty** • Manage patient as if MRSA positive (refer to MRSA Policy) **Date swabs obtained** ..... **Print name**.....

Gastro intestinal risk assessment for CID, norovirus and other gastro-intestinal infections

	Yes	No	Action to be taken
Is the patient presenting at admission with diarrhoeal stool (Bristol stool chart 5, 6, 7) and/or vomiting		✓	If **YES – implement Transmission Based Precautions and isolate patient.** Initiate weekly Bristol stool chart. Send sample to the laboratory.
Has been transferred from any ward/nursing home with suspected or confirmed cases of norovirus.		✓	**Date sample sent** ..... **Print name**.....

Multi drug resistant organism e.g. Carbapenemase-producing Enterobacteriaceae (CPE)

	Yes	No	Action to be taken
Has the patient been • transferred from a hospital outside Scotland • hospitalised outside Scotland in the last 12 months? • Received holiday dialysis outside Scotland • Been a close contact with a person who has been colonised or infected with CPE		✓	**After checking PMS ⚠ if you have answered NO to all** the questions then there is no further action to be taken. If you have answered **YES** to any of the questions you **MUST** screen the patient this includes • Swabs from the **rectum** (& wound or device where applicable) • Manage patient as if CPE positive (refer to CPE Policy) • Inform a member of the Infection Prevention and Control team
⚠ Has the patient been previously positive for CPE at any body site? **(Check case notes and lab results in addition to PMS)**		✓	**NOTE:-IN THE INVESTIGATIONS BOX ON THE LABORATORY REQUEST FORM YOU MUST REQUEST "CPE SCREENING".** **Date swab obtained**..... **Print name**.....

For further advice if required contact the Infection Prevention & Control Team (ext 25765) or the on-call Consultant Microbiologist (via switchboard).

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Nutritional Screening 'Malnutrition Universal Screening Tool' ('MUST')

Food Fluid and Nutrition

Step 1: Measure height and weight to get a BMI score.
Step 2: Note percentage unplanned weight loss and score.
Step 3: Establish acute disease effect and score.
Step 4: Add scores from steps 1, 2 and 3 together to obtain overall risk of malnutrition.
Step 5: Follow the management guidance appropriate to the risk category and commence the corresponding care plan.

Screening Results

11st 2. 5ft 5.

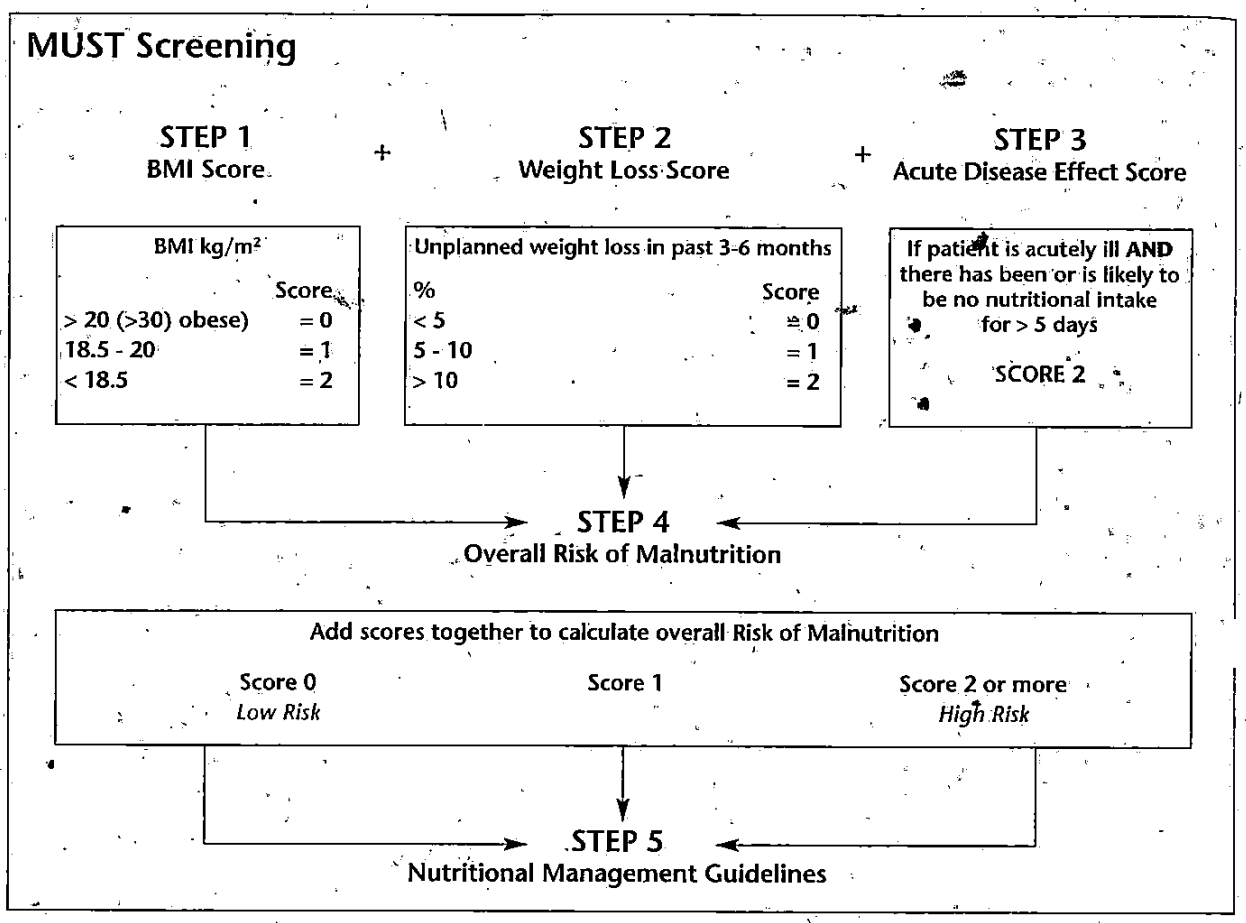
Please indicate if measurements are Measured (M), Reported (R) or Estimated (E)

Date	4/11/18				
Time	1410				
Ward	CAU				
Height (metres) (M) (R) (E)	1.65 m	m			
Current weight (Kg) (M) (R) (E)	70.8 Kg ( )	Kg ( )	Kg ( )	Kg ( )	Kg ( )
BMI	25-9				
Is patient within obese category?					
Usual weight (Kg)	Kg				
Signature					
MUST					
Step 1: BMI Score >20 (>30 = Obese) ..... 0 18.5 - 20 ..... 1 < 18.5 2	0				
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months. <5% ..... 0 5 - 10% ..... 1 >10% 2	0				
Step 3: Acute Disease Effect Score If patient is acutely ill **and** there has been or is likely to be no nutritional intake for>5 days.....Score 2 Not applicable .....Score 0	0				
Step 4: Overall Risk of Malnutrition Total:	0				
Step 5:	0 = Low Risk	1 = Medium Risk	2 or more = High Risk		

Referrals	Consent for referral obtained	Date referred	Signature
Dietician	☐		
Speech and Language Therapy	☐		

Risk Assessment

MUST Screening



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Nutritional Management Guidelines:

MUST Score 0	MUST Score 1	MUST Score 2 or more
Low risk - *Routine Clinical Care* • Commence and implement the **Low Risk Care Plan** • Monitor and review care plan • Repeat screening as below: Acute..... weekly Continuing Care..... monthly	**Medium risk** - *Observe* • Commence and implement the **Medium Risk Care Plan** • Monitor and document dietary intake whilst in ward/department on a Food Record Chart • Encourage oral intake • Assist patient to choose appropriate meals/snacks and offer milk or suitable alternative to drink with and between meals. • Provide nutrition information leaflet to patient. • Monitor and review care plan • **Repeat screening weekly or when next in department.**	**High risk** - *Treat** • Commence and implement the **High Risk Care Plan** • Refer to Dietitian, include MUST score • Continue to monitor dietary intake. • Offer maximum encouragement. • Monitor and review care plan • **Repeat screening weekly or when next in department.** • Consider use of red tray/jug *Unless detrimental or no benefit is expected from nutritional support e.g. imminent death. Use own judgement and document rationale for not treating.

- For low risk patients implement interventions in the **green** section of the care plan, as appropriate.
- For medium risk patients implement interventions in the **green** and sections of the care plan.
- For high risk patients implement interventions in the **green,** and **red** sections of the care plan.
- Always use your own professional judgement when screening patients and making referrals.
- Consider initial admission information relating to eating and drinking needs and preferences.
- When completing Step 2 always compare the most recent weight with the 'usual' weight (or use the initial weight taken on admission if necessary) and not the previous weeks weight.

NHS Ayrshire & Arran

Malnutrition Universal Screening Tool ('MUST') Multidisciplinary Care Plan

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Date of Birth:

Patient Problem
Nutritional screening has identified the patient as being Low ☒ Medium ☐ High ☒ Risk of malnutrition
Patient identified as having other nutritional problems e.g. obesity, chewing certain foods (specify)

Goal
To meet patients nutritional and fluid requirements

Date	Time	Intls	Planned Nursing Interventions/Support	End Date	Intls
			Low Risk Care Plan		
4/11/18	1420	CB	Assistance required (specify) e.g. helping, prompting, cutting up food, opening packets:-		
4/11	1420	CB	Individual / therapeutic dietary requirements (specify) e.g. likes/dislikes religious/ethical/cultural:-		
4/11	1420	CB	Modified eating equipment (specify) e.g. cutlery.		
			Assist patient to select appropriate meals from menu card.		
4/11	1420	CB	Ensure fresh drinking water is offered regularly and available at all times, where clinically appropriate.		
			Consider patients positioning and support oral hygiene, if required.		
4/11	1420	CB	Ensure patients nutritional needs recorded on nutrition board.		
4/11	1420	CB	Monitoring and review care plan **repeat screening weekly** (monthly continuing care).		
			Medium Risk Care Plan (complete low risk section also)		
			Commence food chart for a minimum of 3 days. Only discontinue if/when dietary intake is adequate.		
			If intake is insufficient, offer patient milk to drink with / and between meals and suitable additional snacks.		
			Record accurate fluid intake / output on fluid balance chart until established that oral intake is adequate. If intake per 24 hours is inadequate consider IV/SC fluids.		
			Monitor and review care plan and **repeat screening weekly.**		
			RED TRAY Yes ☐ No ☐ **RED JUG** Yes ☐ No ☐		
			High Risk Care Plan (complete low and medium risk section also)		
			Refer to Dietitian, ensuring the MUST score is included.		
			Discontinue food chart only when advised by Dietitian.		
			Administer and monitor enteral feed via NG/PEG route as per local guidelines.		
			Monitor and review care plan and **repeat screening weekly.**		
			This care plan has been discussed and agreed with the patient as appropriate.		

Risk Assessment

Risk Assessment

Following assessment the Speech and Language Therapist will recommend which texture is suitable for the Individual	
Modified Food Consistency	
Texture B Thin Puree	Smooth consistency with no lumps Can be poured Will slowly drop through prongs of a fork **Thick enough to stand a light plastic teaspoon in**
Texture C Thick Puree	Smooth, moist consistency with no lumps and should not be sticky on palate Cannot be poured Holds its shape on the plate when scooped **No separation of fluids**
Texture D Pre-mashed	Mashed or finely minced before serving Very soft, tender and moist Needs very little chewing **No mixed textures or separation of fluids**
Texture E Fork Mashable	Food must be able to be mashed with a fork Soft, tender and moist Needs some chewing **Meat must be very soft and tender, or minced in thick sauce**

Modified Fluid Consistency	
Stage 1 **Syrup consistency**	Use 1 level scoop of Nutilis Clear in a 200ml drink • This leaves a thin coat on the back of a spoon
Stage 2 **Custard consistency**	Use 2 level scoops of Nutilis Clear in a 200ml drink • This leaves a thick coat on the back of a spoon
Stage 3 **Pudding consistency**	Use 3 level scoops of Nutilis Clear in a 200ml drink • This needs to be taken with a spoon • This will be too thick to drink from a cup

Please record any Therapeutic/Special Diet/Fluids

Texture/Stage/Type (include diabetic, gluten free etc)	Date commenced	Comments	Date discontinued

Please Record if Patient on / Commenced on Supplements
If on supplements please commence supplement monitoring chart

Supplement	Frequency	Any preferences / dislikes	Supplement Chart	On Nutrition Board	Stopped

Any additional interventions (free text)

Further information can be found in the Dietetic Treatment Record

Oral Health Risk Assessment

NA

Rapid Assessment Questions		Circle which is appropriate		Suggested outcome/actions if "Yes" circled
Does the patient need assistance in carrying out their own basic oral care?		Yes	No	If you have answered yes to any of these questions please complete full oral health risk assessment below and review 4-weekly
Does the patient need assistance taking care of their dentures?		Yes	No	
Is the patient suffering from mouth pain?		Yes	No	
What is your normal mouth care routine at home? (for initial assessment only)				Details
Are you having any problems with your teeth or mouth?				Details
Patient Assessment		**Circle which is appropriate**		**Suggested outcome/actions if "Yes" circled**
Smoking habits	Smoker? (which may increase risk of gum disease and oral cancer?	Yes	No	Note amount per day on profile Consider smoking cessation
Dexterity problems	Having difficulty holding toothbrush?	Yes	No	May need supervision/help with mouth care Consider OT adaptation
Cognitive function	Evidence of short-term memory loss and/or confusion?	Yes	No	May need supervision/help with mouth care
Oral Assessment - use tongue compressor and pen torch to examine oral cavity		**Circle which is appropriate**		**Suggested nursing care If "Yes" circled**
Lips	Dry/cracked?	Yes	No	Apply an emollient e.g. lubricating gel
Tongue	Dry/coated?	Yes	No	Clean with soft toothbrush and toothpaste Offer frequent fluids
	Evidence of ulceration/soreness?	Yes	No	If yes, refer to Public Dental Services (PDS)* or advise patient to contact their dentist on discharge
Gums / soft tissue	Evidence of soreness, ulceration, bleeding gums or whiteness?	Yes	No	If yes, refer to PDS* or advise patient to contact their dentist on discharge
Saliva	Dry mouth? (xerostomia) could be side-effect of medication e.g. antidepressants, anticonvulsants etc.	Yes	No	Offer frequent fluids and/or iced water If symptoms persistent refer to dentist
Teeth	Natural top teeth?	Yes	No	Encourage independence with cleaning teeth night and morning. Use toothbrush and fluoride toothpaste (see Basic Oral Care Guidelines for concentration of fluoride)
	Natural lower teeth?	Yes	No	
	Evidence of plaque / debris?	Yes	No	Supervise/help with oral care Use toothbrush and fluoride toothpaste
Dentures	Top denture?	Yes	No	Supervise/help with cleaning dentures night and morning with mild soap and water; rinse dentures after meals. Clean teeth as above Remove dentures at night and leave to soak in water with Milton
	Lower denture?	Yes	No	
	Dentures and natural teeth?	Yes	No	
Pain	When eating/drinking?	Yes	No	If yes, refer to PDS* or advise patient to contact their dentist on discharge
	Caused by teeth/dentures?	Yes	No	
Swallowing	Difficulty with swallowing?	Yes	No	Supervise/help with cleaning teeth and/or dentures and oral cavity after each meal
Nutrition	NBM / Fluid/dietary intake poor?	Yes	No	May require 2 hourly mouth care Check whether oral problems contributing
	Dehydrated?	Yes	No	
	On energy-dense diet or prescribed supplements/snacks?			Consider high fluoride toothpaste if have natural teeth (2800ppm F)

Signed: .....

Date and Time: .....

* Dental Services Helpline: 01563 507 950

For urgent care or advice on weekdays

NHS 24: 111

For dental emergencies out-of-hours

Risk Assessment

Risk Assessment

Oral Hygiene - Care Plan

Write or attach label

HCR No:.....

CHI No:.....

Surname:.....

Forename:..... Sex:.....

Address:.....

.....

Date of Birth.....

Pre Admission Status

Patient has undergone oral assessment and requires assistance with regular mouth care

Goal

For oral cavity to be clean, pink, moist and comfortable

Date	Time	Init's	Planned Nursing Interventions	Discontinued Date/Time	Initial
			Dental Referral		
			• If patient hasn't seen a dentist • If patient suffers from mouth pain • If evidence of ulceration/soreness on tongue • If evidence of ulceration, bleeding gums or whiteness in gums/soft tissues		
			Oral Care		
			If patient is able, prompt by providing adequate opportunity and support to carry out oral care.		
			If patient is dependent, ensure mouth care is offered and provided at regular intervals.		
			If patient has dentures supervise/help with cleaning them night and morning with mild soap and water; rinse dentures after meals. Dentures should be left out and soaked in sodium hypochlorite overnight or for at least 20 minutes, before rinsing and leaving in plain water for the rest of the time. Metal-based dentures should be soaked in chlorhexidine mouthwash.		
			Other Issues		
			If lips are dry apply emollient e.g. lubricating gel.		
			If tongue is dry and coated clean with soft toothbrush and toothpaste and offer frequent fluids.		
			If patient suffers from dry mouth offer frequent fluids and/or iced water. If symptoms persist refer to dentist.		
			If patient has difficulty swallowing you should supervise/help with cleaning teeth and/or dentures and oral cavity after each meal.		
			If patient is nil by mouth or has poor fluid or dietary intake or is dehydrated they may require 2-hourly mouthcare. Check whether oral problems contributing.		
			If patient is on an energy dense diet or prescribed supplements/snacks consider high fluoride toothpaste if have natural teeth.		
			This care plan has been discussed and agreed with the patient as appropriate.		

NHS Ayrshire & Arran

Adapted Waterlow Pressure Area - Risk Assessment Chart

More than one score can be used in each section

Complete assessment according to PPURA or if there is a change in individual's condition and repeat regularly according to local protocol.

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

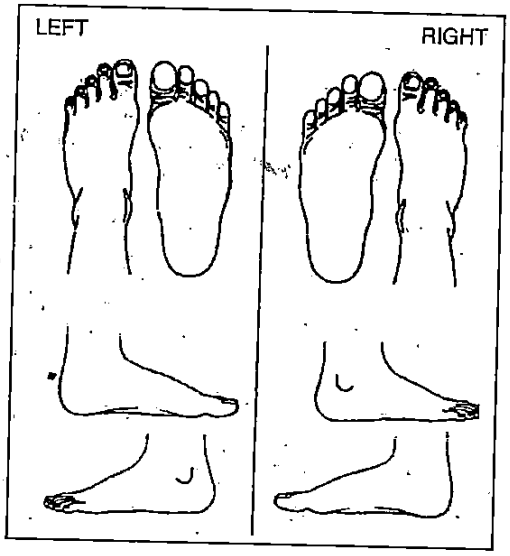
		Date									
		Time									
Sex											
Male 1	Female 2										
Age											
14 - 49	1										
50 - 64	2										
65 - 74	3										
75 - 80	4										
81+	5										
Build/Weight for Height *(BMI=weight in Kg/height in m²)*											
Average - BMI 20-24.9	0										
Above average - BMI 25-29.9	1										
Obese - BMI > 30	2										
Below average - BMI < 20	3										
Continence											
Complete/catheterised	0										
Urinary Incontinence	1										
Faecal incontinence	2										
Urinary and faecaly incontinent	3										
Skin Type - Visual Risks Area											
Healthy	0										
Tissue paper (thin/fragile)	1										
Dry (appears flaky)	1										
Oedamatous (puffy)	1										
Clammy (moist to touch) pyrexia	1										
Discoloured/Bruising/Grade 1	2										
Broken (established ulcer) Grade 2 - 4	3										
Mobility											
Fully mobile	0										
Restless/fidgety	1										
Apathetic (sedated/depressed/reluctant to move)	2										
Restricted (restricted by severe pain or disease)	3										
Bedbound (unconscious/unable to change position/traction)	4										
Chairbound (unable to leave chair without assistance)	5										
Special Risks - Tissue Malnutrition											
Multiple organ failure/terminal cachexia	8										
Single organ failure e.g. cardiac, renal, respiratory	5										
Peripheral vascular disease	5										
Anaemia = Hb < 8	2										
Smoking	1										
Special Risks - Neurological Deficit											
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6										
Special Risks - Surgery/Trauma											
On table > 2 hours (up to 48 hours post op)	5										
On table for up to 6 hours (up to 48 hours post op) provided the rate of recovery is normal)	5										
Orthopaedic/below waist/spinal	8										
Special Risks - Medication											
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4										
	Total Score										
	Initials										

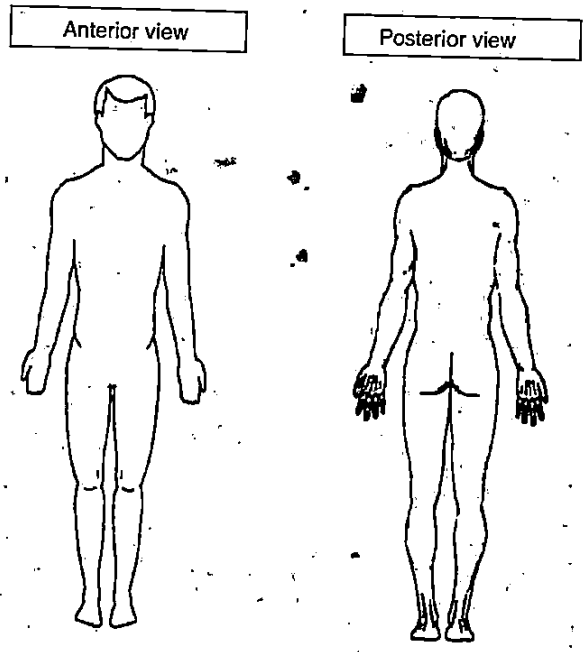
<10 Low Risk - Reassess weekly 10+ At Risk - Reassess twice weekly 15+ High Risk - Reassess on alternate days 20+ Very High Risk - Assess daily	• The Waterlow **must be reassessed** if the patient's condition changes /deteriorates and the plan of care should be reviewed at that point. • For patients who are in long term care, provided their condition is stable after one week of admission the Waterlow can be reassessed weekly/monthly

Risk Assessment

Pressure Ulcer Record

Indicate by circling, numbering and dating all pressure damage on diagrams, then complete box below. Initiate SSKIN care plan/wound assessment chart.





Date	Number of ulcer	Location of ulcer	Grade of ulcer	Datix Insert reference Grade 2-4	Logged on safety cross Grade 1-4	Signature	Print name

Scottish Adapted European Pressure Ulcer Advisory Panel) EPUAP - Pressure Ulcer Grading Tool - 2014

GRADE 1 Intact skin with non blanchable redness, usually over a bony prominence. Darker skin tones may not have visible blanching but the colour may differ from the surrounding skin. The area may be painful, firmer, softer, warmer or cooler than the surrounding tissue.

GRADE 2 Loss of epidermis/dermis presenting as a shallow open ulcer with red/pink wound bed without slough or bruising. May also present as a blister.

GRADE 3 Subcutaneous fat may be visible but bone tendon or muscle is not visible or palpable. Slough may be present but does not obscure the depth of tissue loss. Often includes undermining or tunnelling

GRADE 4 Extensive destruction with exposed or palpable bone, tendon or muscle. Slough may be present but does not obscure the depth of tissue loss. Often includes undermining or tunnelling.

DEEP TISSUE INJURY Epidermis is intact but the area appears purple or maroon or is a blood filled blister over a dark wound bed. Over time the skin will degrade and develop into deeper tissue loss.

UNGRADABLE: Full thickness skin loss where the depth of the ulcer is completely obscured by slough/necrosis. Until enough slough or necrotic tissue is removed to expose the base of the wound the true depth cannot be determined. It may be a grade 3 or 4 once debrided.

All acquired pressure ulcers graded 2 - 4 must be reported via Datix.
Refer to podiatry for at risk feet.

Falls for All Bundle

Please complete for all patients on admission

CHI: 1406650854
H Galloway, Stephen
C 28 Redburn Place
S Irvine
F KA12 9BH
/ 14/06/1965
Dr TG Miller
MRN: XHI468158

1. 5Q's
   a. Has the patient fallen in the last 6 months – including during this admission? Yes ☐ No ☑
   b. Does that patient have cognitive impairment or possible delirium? Yes ☐ No ☑
   c. Does that patient attempt to walk alone although unsteady or unsafe? Yes ☐ No ☑
   d. Does the patient or their relative/s have fear or anxiety, Re falling? Yes ☐ No ☑
   e. Based on your clinical judgement, is this patient at high risk of falling? Yes ☐ No ☑

If yes to any of the above, the patient is deemed as a vulnerable patient and should be commenced on the more vulnerable falls bundle (recording of this is included in care and comfort rounding or alternatively should be recorded in the patients records).

Initials: CB

Date: 4/11/18

Time: 1420

Risk Assessment

Slips Trips & Falls - Care Plan

(To be used in conjunction with the falls for all bundle)

Problem Number:

Write or attach label
HCR No:
CHI No:
Surname:
Forename: Sex:
Address:
Date of Birth

Patient Problem/Need
Patient is considered to be at risk of falling

Goal
To promote and maintain patient safety and reduce the risk of falls

Date	Time	Initial	Planned Nursing Interventions	Discontinued Date/Time	Initial
			Orientate patient and family/carers to ward environment on admission and each shift.		
			Ensure buzzer within reach.		
			Explain importance about calling for help when needed.		
			Ensure that bedside table and key belongings are within easy reach.		
			Ensure patient wears appropriate clothing and footwear.		
			Ensure that patient is wearing spectacles if appropriate.		
			Discuss with family/carers how to assist with interventions.		
			Ensure that patient/family receives an explanation of risk and the measures in place to minimise this risk and document outcome.		
			Ensure that standard bed frame is used and left in a low position with brakes on.		
			Select a chair that is the appropriate height and design for the patient (seek guidance from Physio and OT).		
			When in use ensure that chair/commode brakes are secure.		
			Ensure that area is illuminated appropriately at night time.		
			Liaise with medical team re: medication review.		
			Consider referral to Physiotherapy, Occupational Therapy, Social Work.		
			Monitor lying and standing blood pressure.		
			Supervise patient when transferring as per moving and handling risk assessment.		
			Supervise patient when mobilising as per moving and handling risk assessment.		

			Offer toileting facilities as appropriate.		
			Ensure that patient is cared for in an area proximal to toilet facilities, if possible.		
			Encourage family, if present, to sit with patient (as appropriate).		
			Encourage family/carers to report to nursing station when ending their visit.		
			Consider appropriate equipment in liaison with Physio and / or OT.		
			Ensure yellow sticker is inserted into patient's notes after each fall.		
			Patients who may be confused or have had repeated falls where possible should be cared for in an area within the ward that is within easy view of nursing staff.		
			Check on patient every 15 minutes.		
			Consider a higher level of supervision of the patient.		
			Consider the use of a low level variable height bed.		
			Above care plan has been discussed and agreed with the patient and / or family / carer		

NHS Ayrshire & Arran

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14/06/1965
Dr TG Miller
Date of: XHI468158

Bedrails Risk Assessment

Date of admission: 4/11/18

Please assess **ALL** patient on admission to your ward/departments

- Each statement must be answered - Circle answer
- Complete Risk Assessment in conjunction with Bedrails Algorithm overleaf
- Refer to Guidelines - Safe Use of Bedrails in In-patient Settings & Falls Prevention
- Ensure that you are aware of the safety requirements when using a bedrail, you have undertaken a visual check of the bedrail and that you are satisfied that there are not obvious areas of faults

Re Assessment Occurs

- Weekly
- When the patient's condition changes (i.e. patient falls/post surgery/change in medication/cognitive state changes)

Ensure clear identification of a change in use of bedrails within documentation and at bed space if consent obtained from patient

Risk Factors	Ward: CAU Date: 4/11/18 Time: 1420	Ward: Date: Time:	Ward: Date: Time:	Ward: Date: Time:
1. Is the patient at risk of **falling** from bed?	YES / (NO)	YES / NO	YES / NO	YES / NO
2. Is the patient at risk of **intentionally** climbing over the bedrails?	YES / (NO)	YES / NO	YES / NO	YES / NO
3. Is the patient at risk of **unintentionally** falling from the bed/trolley?	YES / (NO)	YES / NO	YES / NO	YES / NO
4. Does the patient **understand** the purpose of the bedrails? Consider communication difficulties and physical/Cognitive condition.	(YES) / NO / NA	YES / NO / NA	YES / NO / NA	YES / NO / NA
5. Does the patient **consent** to the use of bedrails?	YES / (NO) / NA	YES / NO / NA	YES / NO / NA	YES / NO A
Has the Bedrails Algorithm been followed?	Yes ☑ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
According to the Bedrails Algorithm are bedrails required / appropriate?	Yes ☐ No ☑	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Bumpers required	Yes ☐ No ☑	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Initials	CB			

If Yes, commence a Safe Use of Bedrails Care Plan. If No, state reason why bedrails are not required.

Risk Assessment

Bedrails Algorithm

Complete the NHS Ayrshire and Arran Slips Trips and Falls Assessment Tool

Is the patient at risk of falling from bed/trolley?
NB: for patients at risk of climbing over bedrails, alternatives must be considered. See boxes 2+3

Yes

Patient understands purpose of the bedrails

- Patient consents to bedrail use → Bedrails could be used with caution. See boxes 1 + 3 below
- Patient declines bedrail use → Bedrails inappropriate see boxes 2+3

Patient does not understand purpose of bedrails due to .....

- Communication difficulties → Consider:
  - Referral to appropriate speciality e.g. audiology
  - Use of interpreter
  - Use of written or pictoral information
- Physical and/or cognitive condition → Consider actions in patient's best interest. See boxes 1, 2 + 3 below → Agree plan of care with Next of Kin and document outcome in nursing records

No

- Patient requests bedrails → Bedrails could be used with caution. See boxes 1 + 3 below
- Patient not requesting bedrails → Bedrails inappropriate see box 3

1. If bedrails are used consider:

- Risk of entrapment and harm to limbs
- Risk of patient climbing over the top
- The psychological effect of their use on the patient
- Ensure bed returned to lowest height after care delivery
- Use of the Dynamic mattress increases the height of the bed

2. Alternatives to bed rails

- Use of variable height bed
- Additional mattress/crash mat beside bed
- Close observation of patient
- Ensure bed returned to lowest height after care delivery
- Ensuring patient needs anticipated e.g. drinks are accessible, regular toileting, call bell to hand etc
- Nursing patient on mattress on the floor should be a last resort and safety checks should be made for hot pipes, electric sockets etc. Manual handling risk assessment for staff must be undertaken

3. Remember to document in nursing records:

- Date and time assessment made
- Rationale for decision made in care plan
- Actions taken, including discussion with Next of Kin
- Care planning

Assessment should be made:

- On admission
- If patient's condition changes
- Weekly

Risk Assessment

Safe Use of Bed Rails - Care Plan

Write or attach label

HCR No:.....

CHI No:.....

Surname:.....

Forename:..... Sex:.....

Address:.....

.....

Date of Birth.....

Patient Problem/Need
The patient is at risk of falling out of bed due to (e.g. cognitive or physical condition)

Goal
To promote and maintain patient safety and reduce the risk of falling out of bed

Date	Time	Initial	Planned Nursing Interventions	Discontinued Date/Time	Initial
			Ensure assessment is made on admission, when patient's condition changes, and weekly as a minimum.		
			Ensure rationale for decision made re; the use of bedrails is clearly documented.		
			Consider psychological effects of bedrail usage on patient and where appropriate ensure the patient's consent to their use.		
			Ensure risk of entrapment is minimised by careful positioning of patient prior to operating bedrails.		
			If detachable bedrails used, ensure the gap between the top end bedrail and head of bed is less than 6cm or more than 25cm.		
			If detachable bedrails used, ensure the gap between the bottom end of bedrail and foot of bed is more than 25cm.		
			Continually monitor risk of patient climbing over the top of bedrails and assess the use of bedrails as necessary.		
			Discuss with the patient, the need to share information with other nurses and health care workers re; the use of bedrails, and document within the nursing documentation whether the patient consents to display information at the bed space.		
			Provide Falls/Use of Bedrails information leaflet to patient. Where the patient is incapacitated, ensure that relative/carer is given a leaflet and information about the assessment for bedrails is provided.		
			Ensure all actions, including discussions with relative/ carer are documented.		
			Refer to the Safe Use of Bedrails in Adult In-Patient Settings Guideline for further guidance on the management of bedrails.		
			Re-assess the need for bedrail use at least weekly or as the patient's condition indicates and document on the risk assessment chart.		
			This care plan has been discussed and agreed with the patient as appropriate.		

Moving & Handling
Patient Risk Assessment

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158
Date of Birth.....

All Patients:

Sliding aids **must** be used bed to trolley/bed unless the patient transfers independently
A hoist **must** be used if assistance is required from the floor
A hoist **must** be used for bathing unless independently mobile
Hoists are for lifting patients and must not be used for transport between rooms

Special Alerts: Date:						
Overweight / Obese (BMI definition)						
Very tall (>185cm in height)						
Restricted use of limbs						
Poor standing ability						
Sedation or lethargy						
Irrational behaviour / confusion						
Unable to co-operate						
Acute pain						

Assessment of Risk:

Low Risk: Independently mobile / supervision only required. Aids required should be specified in care plan

Moderate Risk: Requires physical assistance from one or more handlers. Is able to stand or partially bear weight and has no more than one special alert.

High Risk: (a) Is unable to bear weight and requires assistance.
(b) 2 or more special alerts present and requires assistance.

Aids, equipment and a minimum of 2 handlers recommended to move a patient.

Specify Level of Risk

Date:	4/11/18					
LOW RISK	✓					
MODERATE RISK						
HIGH RISK						
Assessor's Initials	CB					

If a hoist or standing aid is required please specify:

Sling type:		**Size:**		**Manufacturer:**	

Additional Comments:

Risk Assessment

Risk Assessment

MOVING AND HANDLING CARE PLAN

Date:	4/11/18					
1. Moving in bed:						
a) Independent	a) ✓					
b) Handlers and sliding sheets required to move in bed - specify number of handlers in grid	b)					
c) Specify any additional equipment required in grid	c)					
2. Sitting to Standing:						
a) Independent	a) ✓					
b) Requires assistance from sit/stand to sit? Specify number of handlers in grid	b)					
c) Also requires aids. Specify equipment in grid	c)					
4. Transfers: (chair / wheelchair / commode / toilet / bed)						
a) Independent or with minimal supervision	a) ✓					
b) Assistance required from handlers specify number of handlers in grid.	b)					
c) Equipment required - specify equipment in grid	c)					
4. Adjusting Clothing						
a) Independent or minimal supervision	a) ✓					
b) Can use support/grab rails while assistance is given with clothing	b)					
c) Requires support from Handler(s) while another assists with clothing	c)					
d) Requires equipment, specify equipment in grid	d)					
5. Repositioning in chair / wheelchair:						
a) Independent or minimal supervision	a) ✓					
b) Assistance from handler(s), specify number in grid	b)					
c) Specify other aids or equipment required in grid	c)					
6. Mobilising:	Documented in Mobility Care Plan					
Assessors initials	CB					

If it is decided to stand, transfer or mobilise a patient requiring assistance of more than 2 handlers, without equipment, a detailed assessment outlining the decision making process must be documented in the mobility careplan.

Mobilising - Care Plan

Write or attach label
HCR No:.....
CHI No:.....
Surname:.....
Forename:..... Sex:.....
Address:.....
.....
Date of Birth.....

Patient Problem/Need
Patient has restricted mobility/mobility is deteriorating due to.....
Goal
To optimise ability to mobilise safely and maintain independence as much as possible

Date	Time	Initial	Planned Nursing Interventions	Discontinued Date/Time	Initial
			Refer to moving and handling risk assessment tool and plan care accordingly.		
			Mobilise/transfer with assistance of one/two handlers.		
			Mobilise/transfer with supervision.		
			Mobilising with appropriate handling equipment and/or aids, please state:-		
			• Walking stick one/two		
			• Tripod/quad		
			• Zimmer frame/rolator		
			• Wheel chair		
			• Hoist aid (specify equipment used)		
			• Other (please specify)		
			Refer to physiotherapist and action specialist requirements.		
			This care plan has been discussed and agreed with the patient and/or carer/relative as appropriate.		

Referrals to Multidisciplinary Team During Admission

Date	Initials of staff making referral	Referrals	Contact Number/ Page	Date Reviewed	Initials
		Alcohol Liaison Team			
		Community Learning Disability Team			
		Community Mental Health Team			
		Community Mental Health Team Elderly			
		Community Nurse			
		Community Psychiatric Liaison Team			
		Community Psychiatric Liaison Team Elderly			
		Dental			
		Diabetic Team			
		Dietitian			
		Discharge Co-ordinator			
		Fresh Air-shire			
		Home Care Organiser			
		Intermediate Care and Enablement Services			
		Occupational Therapist			
		Palliative Care Team			
		Pain Team			
		Pharmacist			
		Physiotherapist			
		Podiatrist			
		Psychiatric Liaison Team			
		Speech and Language Therapist			
		Social Worker			
		Specialist Nurse			
		Tissue Viability			
		Other - please specify			

Care Plans and Monitoring Charts Evaluation

Write or attach label

HCR No:.....

CHI No:.....

Surname:.....

Forename:..... Sex:.....

Address:.....

.....

Date of Birth.....

Code	Care Plan / Monitoring Chart
A	Admitted as an emergency
B	Breathing
C	Catheter
D	Cleansing and dressing
E	Elimination
F	Falls
G	Bedrails
H	Mobilising
J	Communication
K	Pre - operative
L	Post - operative
M	Wound Management
N	Pressure area care
O	Oral Hygiene
P	Pain Management
R	MUST - Eating and Drinking
S	Emotional Wellbeing/Anxiety
T	MRSA
V	MEWS
W	Fluid Balance Chart
X	PVC Chart
Y	Investigations
Z	Cognitive impairment

Code	Additional specific care plans / monitoring Charts
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
21	

Care Plans

Initial Presentation and Plan

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158
Date of Birth:

Ward _____

Date & Time	Immediate presenting history (inc GP, ED or clinic)	Initials
4/11/18	Abdo pain Alcohol Withdrawal. Drinks 1-1.5L spirits per day Vomiting yesterday (°bloody) + Watery diarrhoea (°bloody, °melaena) pain crampy - non-localised. Feels tremulous like withdrawing from alcohol.	
Date & Time	**Medical/ANP Initial Plan**	**Initials**
4/11/18	SIB medics imp- ① Probable alcoholic gastritis ② Alcohol withdrawal plan- peptac pabrinex CIWAWS PRN.	

Ward Round Instructions / Goals of Care

Write or attach label
HCR No:
CHI No:
Surname:
Forename: Sex:
Address:
Date of Birth

Ward CAU

Date & Time	Ward Round Instructions	CLD	EDD	Initials
5/11/18	1025 - IMPression: Alcohol Withdrawal Construction.			
	Plan/Pabrinex			
	GMans			
	AIC. Liason			
	Laxatives			
	GMans assessment → regular benzos.			
	Monitor BP.			
	Bloods tomorrow → LFTs settling.			
	Allocate → GEN			MC(SHO)/KM
6/11/18 1120	Reviewed by Dr. Plans ↓ dose diazapam 15mg QDS.			
	continue GMans/pabrinex.			
7/11/18 1035	Pt r/v'd by Dr Al-Dallal pt refused to take reg diazepan occassionaly as makes him feel dizzy			
	(P) ALN r/v'd			
	-update bloods ✓			KF
7/11/18 1305	Pt r/v'd by Dr Al-Dallal (P) liver screen ✓			
	-O/P USS abdo			
	-to return 9/11/18 to RAA for rpt LFT			
	- Alcohol laision will contact him later today			
	- D/C with worsening advice			KF

Ward Round Instructions

Ward Round Instructions

Ward _____

Date & Time	Ward Round Instructions	CLD	EDD	Initials

Write or attach label

HCR No:.....

CHI No:.....

Surname:.....

Forename:..... Sex:.....

Address:.....

.....

Date of Birth.....

Ward _____

Date & Time	Ward Round Instructions	CLD	EDD	Initials

Ward Round Instructions

Ward _____

Date & Time	Ward Round Instructions	CLD	EDD	Initi

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158
Date of Birth.....

Ward _____

Nursing Care Evaluation

Date & Time	Care plan Code	Nursing Evaluation	Initials
4/11/18	S	Patient admitted to Amb care.	
1400		Orientated to ward.	
	V	NEWS-0	
	P	Pain free at present.	
		Score - 3 on CIWANS - given	
		10mg diazepam as charted.	
		Patient now cannulated.	
		IV pabrinex given	
		IV fluids continue.	CB
1600		Given further 10mg of	
		diazepam. CIWANS score	
		- 1. Nil concerns at present.	CB
1900	S	Patient settled in bed	
	V	NEWS as charted	
	P	NO c/o pain or nausea.	
		IV fluids continue.	
		Nil concerns at present —	CB
2010		CIWANS score 1. Diazepam 10mg given	
		Pt had disconnected his IV fluids &	
		went outside, advised not to do this	
		given buzzer to alert staff if	
		needs to be disconnected.	MC
04/11/18 2035		Pt has been touching IV fluid admin set,	
		clamp opened up full, advised pt not	
		to touch admin set. Pt advised he	
		is going to meet friend at 9pm outside	
		to get fresh clothes ———	MC
2130		Pt went outside at approx 20:50, went	
		to meet friend who was dropping belongings	
		has left jumper at bedside. Pt has not	

Nursing Care Evaluation

Ward _____

Date & Time	Care plan Code	Nursing Evaluation	Initials
		returned to unit. AN went outside CAN, no sign of pt. Pt has jacket on Pt has cannula in situ. Pt was seeing on computer (a), oriented to place/person. Tried phoning pts mobile - switched off. Band 6 informed.	
2170		Returned to ward had been in carpark talking to friend who dropped off mobile charger. Advised not to leave unit for that length of time	
2200		IV paboress in situ	
2345		settled and asleep at present	
05/11/18		Self caring with personal needs prior to settling	
0225		Not seen on rounds. Feels well. Slept for short spells so far	
0535		NEWS 0 but BP remains elevated. Went out for cigarette. GMANS score 0 Pt feels well	
0635		- 10mg diazepam given GMANS score (1) tremors on outstretched arms	
05/11/18	08:30	Breakfast taken, due meds given, PVC patent IV meds insitu, GMANS = 1 10mg Diazepam given	
05/11/18	09:40	NEWS = 1 (error) pain free, pt had shower, outside for cigarettes	
05/11/18	10:30	R/V Dr Smith - cont Pabrinex/ GMANS, Alcohol Liason, Laxatives, GMANS assessment - regular benzos, monitor BP	cont

Write or attach label

HCR No:
CHI No:
Surname:
Forename: Sex:
Address:
Date of Birth

Ward AC/CAV

Date & Time	Care plan Code	Nursing Evaluation	Initials
05/11/18	cont'd	bloods mane. Pt aware of plan	KM
05/11/18	11.00	GMAWS = 0, pt off ward for coffee with friend - to return in thirty minutes, pt aware non complaining	KM
05/11/18	12.15	Pt refused lunch, 20mg regular Diazepam given, pt outside using phone	KM
05/11/18	13.50	NEWS = 0, BP remains on high side although not scoring. IV Labrinex given, pt settled	
05/11/18	13.55	AAMAWS = 1 pt declined further diazepam at this time	KM
5/11/18	15.00	GMAWS = 1, 10mg diazepam given, pt settled in chair, continue to monitor	KM
5/11/18	17.00	GMAWS = 1 pt refused Diazepam, starting to feel "woozy" with Diazepam otherwise pt settled continue to monitor	KM
5/11/18	19.00	GMAWS = 1, 10mg Diazepam given, d/w ANP Hastie re:- regular dose - to be witheld and to give as required on GMAWS - monitor for dizziness / drowsy. Pt settled, c/o sore R/J shoulder advised to d/w team at r/v in mane	KM

Nursing Care Evaluation

Nursing Care Evaluation

Ward _____

Date & Time	Care plan Code	Nursing Evaluation	Initia
05/11/18 23⁰⁰	S	Patient settled in bed	
	V	NEWS-1 (HR↑98)	
	P	No c/o pain or nausea. Medication given as charted. Cannula dislodged. Will require new one in am.	CB
0230		Patient settled and asleep, not requiring diazepam overnight. Nil concerns. —	● CB
0640	S	Patient settled at bedside. Independent with ADLs.	
	V	NEWS-1 (HR↑94)	
	P	No c/o pain or nausea Given 10mg diazepam as per GMMMS.	
	R	Given cup of coffee. Nil concerns. ——	CB
6/11/18 0940	E	Urine obtained	
	H	Independently mobile.	●
	R	Breakfast taken. Medications given as charted. Paracetamol not administered yet as cannula not in place this morning. This has been inserted by GSW.	
	J	Pt asking to go off ward to go and see someone he knows in main part of hospital. I explained to the pt I would prefer if he didn't leave the ward as we are still going thru treatment & needs	

CHI: 1406650854
H Galloway, Stephen
C 28 Redburn Place
S Irvine
F KA12 9BH
A 14/06/1965
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Date of Birth

Ward CMU/AC

Nursing Care Evaluation

Date & Time	Care plan Code	Nursing Evaluation	Initials
		observation. He was certain he was leaving & will be back within 1/2 an hour. I advised not to, pt left ward with cannula insitu. Await pt return.	
6/11/18 1045	X	IV paracetamol administered when pt returned to ward. Q4hrly observations. PRN diazepam given.	
6/11/18 1350		Regular / fixed dose reduced. Pt not tolerating 2mg regular now 1.5mg. Mobile around ward area.	
6/11/18 1850		Medication given as charted & known. No complaints. Pt restless at times. Dinner taken. Patient settled Meds as entered. Diazepam 2200 dose withheld as patient asp. Had tea / Biscs @ night Not snoring on rounds.	
7/11/18 0850	D	Pt arrived from AMU Cave to Rapid Assessment Had light breakfast Independent with ADLs prior to	

Nursing Care Evaluation

Ward _____

Date & Time	Care plan Code	Nursing Evaluation	Initia
7/11/18. 0850		Transfer. Pt states cannula no longer insitu, D/W Dr Chris not to give IV pabrinex. Await ALN then can be d/c home ———	UF
1050.	4	Bloods obtained as per plan. smoking disclaimer signed. Await alcohol liason.	
7/11/18. 1200		Have radiopaged ALN as awaiting r/v ———	CF
7/11/18 1300		Spoken to ALN on telephone unable to r/v on ward today however can do telephone consultation this afternoon. Spoken to pt who has consented to this. Advised from ALN that if pt is having DTs when d/c pt to have drink alcohol. Spoken to pt re: symptoms of DTs. Liver screen carried out. Pt r/v'd by Dr Abdullah pt to return to Rapid @ 9AM for rpt LFTS. Pt now d/c from unit, will return to EAA 9AM. ALN will phone pt this afternoon. Pt aware of plan ———	UF.
9/11/18 0930		(Rpt LFTs carried out. Awaits results. Attended rapid assessment as O/P).	KE

Our purpose

Working together to achieve the healthiest life possible for everyone in Ayrshire and Arran

NHS Ayrshire & Arran

Name: Stephen Calloway.

CHI Number: 1406650854

SB

PATIENT PROFILE

Please complete below when patient is admitted or transferred to your clinical area

	Admission		Transfer 1		Transfer 2		Transfer 3	
Hospital	XH							
Ward	CAU							
Consultant	Dr Smith.							
Date / Time	13/8/18	1400						
Relative Informed	Yes	~~No~~	Yes	No	Yes	No	Yes	No
ID Band in situ	Yes	~~No~~	Yes	No	Yes	No	Yes	No
Completed By - Signature	TPt							

The Patient Profile can be used for patients with ongoing regular treatment i.e. for a course of therapy or weekly blood transfusion, however if there is a gap of more than 6 weeks since last attendance repeat lifestyle assessment (p15).

If the patient is readmitted into UHC or UHA an additional MRSA/CRA (p20) must be completed. Additional forms can be obtained from the infection control AthenA site.

This profile can also be used for readmission within 3 days.
Please remember to review earlier risk assessments.

Property handed over for safe keeping

PLACE VALUABLES STICKER HERE

Our values

Clinical Team Signatures

All staff completing the documentation **must** complete this section

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158
Date of Birth.....

Name (BLOCK CAPS)	Profession	Ward/ Page No	Signature	Initials
TPATON	S.N	CAU	TPat	TP
SKOWLOWAY	JN	CAU	SKowlowy	SK
K. MaxwellV	Qvit Your Why	Ext: 25835	KS	KWM
PAULENE CURRIE	SN	CAU	PCurrie	PC
CATHERINE MCKEAN	SN	5B BANK	CMcKean	CM
LESLEY QUINSMUIR	S/N	5B	Lesley Quinsmuir	LQ
A REID	S/N	ACC	AReid	AR

Colour codes for sections within

Risk Assessment	Lifestyle Assessment
Personal Details	Patient/Family Communication
Care Plans	MDT Discharge Plan
Ward Round Instructions	Nursing Care Evaluation
MDT Communication	

SCN - Senior Charge Nurse
STN - Student Nurse
DCN - Deputy Charge Nurse
HCA - Health Care Assistant
RN - Registered Nurse
HCSW - Health Care Support Worker
AHP - Allied Health Professional

Abbreviations

This abbreviation list has been approved for use by NHS Ayrshire & Arran

ANP	Advanced Nurse Practitioner	ICES	Intermediate Care and Enablement Services
ABG	Arterial Blood Gas	ICU	Intensive Care Unit
BM	Blood Glucose Monitoring	IM	Intramuscular
BMI	Body Mass Index	INR	International Normalised Ratio
BO	Bowels Open	IV	Intravenous
BP	Blood Pressure	LFTs	Liver Function Tests
CABG	Coronary Artery Bypass Graft	L+S BP	Lying and Standing Blood Pressure
CAU	Combined Assessment Unit	MAR	Medication Administration Record
CCU	Coronary Care Unit	MEWS	Modified Early Warning Score
CDI	Clostridium Difficile Infection	MHC	Medical High Care
CDU	Clinical Decisions Unit	MI	Myocardial Infarction
CHI	Community Health Index	MRI	Magnetic Resonance Imaging
CKD	Chronic Kidney Disease	MRSA	Methicillin Resistant Staphylococcus Aureus
CLD	Criteria Led Discharge	MSSU	Mid Stream Specimen of Urine
CLDT	Community Learning Disability Team	MUST	Malnutrition Universal Screening Tool
COPD	Chronic Obstructive Pulmonary Disease	NAD	No Abnormalities Detected
CPR	Cardio Pulmonary Resuscitation	NBM	Nil By Mouth
CRP	C - Reactive Protein	NG	Nasogastric
CSU	Catheter Specimen of Urine	NOF	Neck of Femur
CSW	Clinical Support Worker	O2	Oxygen
CT	Computerised Tomography	OT	Occupational Therapist
CVC	Central Venous Catheter	PEG	Percutaneous Endoscopic Gastrostomy
DOB	Date of Birth	PICC	Peripherally Inserted Central Catheter
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation	PMH	Past Medical History
ECG	Electrocardiogram	PN	Parental Nutrition
ED	Emergency Department	PVC	Peripheral Vascular Catheter
EDD	Estimated Date of Discharge	SP02	Saturation of Peripheral Oxygen
ERCP	Endoscopic Retrograde Cholangiopancreatography	SBAR	Situation Background Assessment Recommendations
ERT	Emergency Response Team	SC	Subcutaneous
ESBL	Extended Spectrum Beta Lactamase	SLT	Speech and Language Therapy
ESR	Erythrocyte Sedementation Ratio	TFTs	Thyroid Function Tests
FBC	Full Blood Count	USS	Ultra Sound Scan
GP	General Practitioner	U&Es	Urea and Electrolytes
H@N	Hospital at Night	UTI	Urinary Tract Infection
HAI	Healthcare Associated Infection	WCC	White Cell Count
HDU	High Dependency Unit	WZF	Wheeled Zimmer Frame

Personal Details

Prefers to be known as: Stevie	Age: 53
Receiving Consultant: DR Smith	Allocated Consultant:
From where: IA	Accompanied by:
Emergency ☐ Elective ☐	Patients telephone number:
	Patients mobile number:

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14/06/1965
Dr TG Miller
MRN: XHI468158

GP Name:
GP Address:

Reason for Admission	Next of Kin/First contact/Significant other
Alchol. withdrawl. Stopped 24hrs ago Falls.	Name: Jeana Fraser Address: 36 Dunton. Rd Irvine Relationship to patient: ex Partner Contact No(s) Home: Mobile: Aware of admission Yes ☐ No ☑ Contact overnight Yes ☐ No ☑ Consent to share information with significant other listed: Yes ☐ No ☐
Patients Account of Reason for Admission	**Second contact/significant other**
	Name: Address: Relationship to patient: Contact No(s) Home: Mobile: Aware of admission Yes ☐ No ☐ Contact overnight Yes ☐ No ☐
Specific Alerts	**Specific Alerts**
Previous known MRSA Yes ☐ No ☑ Ensure risk assessment completed Clostridium Difficile Yes ☐ No ☑ ESBL Yes ☐ No ☑ Other infectious conditions? Yes ☐ No ☑ Specify:	Drug Allergies: Other allergies (food, latex, etc) None known ☑

Observation on admission	+ ++ +++ ++++	+ ++ +++	+ ++ +++ ++++	+ ++ +++	-ve +ve
Urinalysis NAD ☑	Protein Trace	Blood Trace	Glucose Trace	Leucocytes Trace	Nitrates
MSSU collected?		Yes ☐	No ☑	Date.....	
Glucometer Reading: Yes ☐ No ☐ Result:.....	Date Last Menstrual Period (if appropriate)			Pregnancy Test (if appropriate) +ve ☐ -ve ☐	

Pain Score	low						severe				
	0	1	2	3	4	5	6	7	8	9	10
For patients with cognitive impairment please refer to Abbey pain scale											

Previous medical, surgical and mental health history

Details	Date (if Known)	Details	Date (if Known)
Alchol. ex.			
D.Ts.			

Medications

Any important information regarding medications.....

Own medication retained on ward Yes ☐ No ☐ Where stored.....

Have the medications been returned to relatives? Yes ☐ No ☐ ☐ N/A

Please complete below when patient is admitted or transferred to your clinical area

	Ward: CAU		Ward:		Ward:	
Verbal information given to patient and / or relatives:	Date:		Date:		Date:	
	Yes	N/A	Yes	N/A	Yes	N/A
Call buzzer If patients unable to use buzzer ensure this is reflected in care planning	✓					
Toilets / Bathroom	✓					
Explained Protected Mealtimes	✓					
Visiting times	✓					
Hand hygiene	✓					
Valuables	✓					
Smoking						
Patient Discharge Booklet given						
Other						
Sign						

Patient's Property - Where possible send belongings home with family

You are asked to keep belongings/valuables to a minimum whilst in hospital. You are responsible for property belonging to you not handed over for safe custody. This includes cash, spectacles, hearing aids, dentures and other personal items and valuables. Valuables should be sent home at first opportunity or given to the nurse if this is not possible.

Valuables handed over for safe keeping will be sent to the cashier's office and a receipt will be issued. If patient lacks capacity please ensure relevant documentation is completed for belongings and valuables.

Signature of Patient / Significant Other: _____ Date 13/8/18

Property handed over for Safe Keeping: Yes ☐ No ☐ Sticker on front page: Yes ☐ No ☐

Date taken to Cashier: _____ Cash & Valuables Ref No: _____ Date Returned: _____

Personal Details

Personal Details

Cognitive assessment

	Circle		
	1st Assessment	Further Assessment	Further Assessment
	Date	Date	Date
To be completed on all patients over 65 or if appropriate or if the patient has suspected delirium Ask the patient the following questions: (4AT)			
1. ALERTNESS This includes patients who may be markedly drowsy (eg. Difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gently touch on shoulder. Ask the patient to state their name and address to assist rating			
Normal (fully alert), but not agitated, throughout assessment)	(0)	0	0
Mild sleepiness for <10 seconds after waking, then normal	0	0	0
Clearly abnormal	4	4	4
2. AMT4 Age, date of birth, place (name of the hospital or building), current year.			
No mistakes	(0)	0	0
1 mistake	1	1	1
2 or more mistakes/untestable	2	2	2
3. ATTENTION Ask the patient "Please tell me the months of the year in backwards order, starting at December". To assist initial understanding one prompt of "what is the month before December?' is permitted.			
Months of the year backwards, Achieves 7 months or more correctly	(0)	0	0
Starts but scores <7 months / refuses to start	1	1	1
Untestable (cannot start because unwell, drowsy, inattentive)	2	2	2
4. ACUTE CHANGE OF FLUCTUATING COURSE Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. Paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs			
No Yes	(0)	0	0
4 or above: possible delirium +/-cognitive impairment: refer to algorithm	4	4	4
1-3: possible cognitive impairment			
0: delirium or cognitive impairment unlikely (but delirium still possible if question 4 information incomplete)			
If 4AT of 4 or above commence Time Bundle			
4AT SCORE	0		
SIGN	TP		

If you have concerns regarding capacity, please refer to algorithm and dementia/delirium care plan.

If no 4AT carried out please document reason eg Patient unconscious.....

Informed Consent and Capacity

While undertaking the patient's clinical assessment, if you have any concerns regarding the patient's capacity and ability to make healthcare decisions refer to medical staff for **assessment and treatment plan** under the Adults With Incapacity (Scotland) Act 2000 and document your actions within the nursing notes. Refer to the Consent policy for further guidance.

Information about the patient can be obtained from relatives and carers including legal guardians (e.g. guardianship through the social work department)

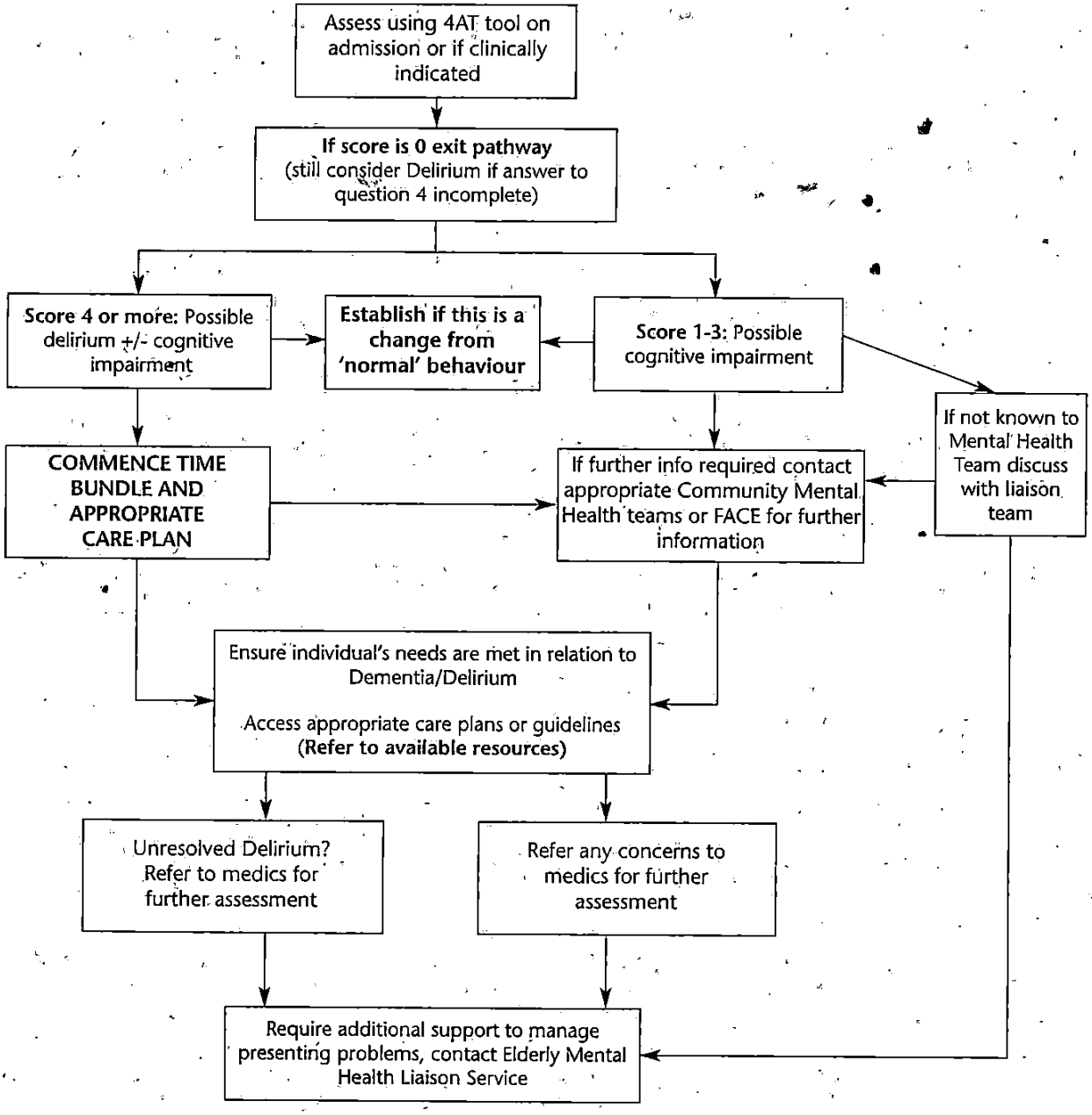
Relatives and carers cannot make decisions for patients except in certain circumstances where they hold Welfare Guardianship or Power of Attorney extending to health care decisions under the Adults With Incapacity (Scotland) Act 2000.

	Yes	No			Names
Advanced Statement	☐	☐			.....
Power of Attorney details	☐	☐	Financial ☐	Welfare ☐	.....
Guardianship details	☐	☐	Financial ☐	Welfare ☐	.....
"Getting to know me" in use	☐	☐			.....

If yes to any of the above obtain a copy of the relevant document.

If diagnosis of dementia is confirmed please ensure appropriate documentation / care plans are initiated

Nursing Assessment and Management of Cognitive Impairment



Personal Details

Useful Contact numbers

If patient has diagnosis of dementia and lives:
Nursing/Care Home: Contact **Elderly Mental Health Care Home Liaison Nurse** who will be able to provide background information regarding patient and support discharge arrangements.

Telephone no:.....

At home: Contact **Community Mental Health Team** as patient likely to be known to them>they may offer advice and/or background info.

Telephone no:.....

If patient does not have a diagnosis of dementia but further advice/support req'd whilst an in-patient, contact: **Elderly Mental Health Liaison service**

Telephone no:.....

If patient is known to any of the Mental Health Teams please inform when fit for home/discharge plans.

Useful Available Resources

Access if available:

Getting to Know Me - hand held document used by patients

Dementia Care Plan - for pts with a diagnosis of dementia

Delirium Care Plan - for pts displaying symptoms indicative of delirium

Identification and Management of Delirium in the Elderly - can be found on back of Delirium Care Plan

Behavioural and Psychological Symptoms associated with Dementia - a guide to cause and management in behaviour that challenges in delivery of care of patients with dementia

Abbey Pain Scale - pain tool that should be used for pts with dementia and/or who cannot verbalise

Time Bundle - Time Bundle for patients with 4AT of 4 or more

All of the above resources can be accessed through Athena or in Dementia Resource Folder if available.

Personal Details

Adult Support and Protection – 3 point criteria

An adult who:

- Are unable to safeguard their own well-being, property, rights or other interests
- Are at risk of harm; and
- Because they are affected by disability, mental disorder, illness or physical or mental infirmity are more vulnerable to being harmed than adults who are not so affected.

Harm includes:

- All harmful conduct and in particular:
- Conduct which causes physical harm;
- Conduct which causes psychological harm (for example by causing fear, alarm or distress);
- Financial harm
- Conduct which causes self-harm

If you have a concern about an adult who you believe is or may be at risk of harm complete an ASP/Concern referral.

ASP / Concern referral submitted Yes ☐ No ☐

All referral information can be found on AthenA Adult Support and Protection site.

Consent to display limited information

Patient consents to display of CHI number and limited personal information about care (e.g. bedrails, diet, mobility, "forget me not") on a chart at the bedside and whiteboard etc.

Consent given: Yes ☑ No ☐ By whom: Patient ☐ Relative/Carer ☐

If the patient has declined to consent to information being displayed at the bed space please provide information here .....

Nurse Initials TP/E Date 13/8/18

Useful Contacts:

To support your plan of care for this patient you might find it helpful to contact the relevant liaison service below:

Learning Disability Liaison Nurse Specialist:	01294 323560 (north) 01292 614910 (south) 01563 578574 (east)
Mental Health Liaison Nurses (Elderly Services)	01292 513007
Psychiatric Liaison Nurse (Adult general hospitals)	01563 826120
Advocacy Services	01294 608664 (north) 01292 264396 (south) 01563 574442 (east)
Hospital Social work team	Hospital site contacts through switchboard.

Additional relevant information (including details of the relevant liaison service contacted)

Person-centred care is where the patient is an equal partner with the health or care professional and where both parties work together to make an assessment, identify options for and the delivery of the most appropriate care. The care provided is holistic and the 'whole person' sits at the centre of the care package, which may be delivered by a range of health and social care professionals.

To promote person-centred care our focus is changing from asking 'What's the matter with you' to asking 'What matters to you'. We can do this by reliably covering the five 'Must do with me' elements of care with patients and/or their families and carers. This will help to ensure all of the interactions between people using our services and the staff delivering them are person-centred and are characterised by listening, dignity, compassion and respect.

5 Must do's. These can be answered by patient/family/carers

What is important or matters to you?

What are the most important things for you that we can help you with/ do for you while you are here? e.g; *'that my wife/husband can be present when the consultant talks to me'; 'that I can choose my meal rather than someone else choosing it for me'; 'that my pet has been taken care of'; 'that my medication is given at the right time';*

Help me get off the drink.

Who matters to you?

Who are the most important people to you and how would you like them involved in your care? eg. family, friend, chaplain, minister, priest.

2 daughters 12 & 15 yrs.

What information do you need?

eg when will the doctor see me'; 'visiting times'; 'meal times'; 'Can I smoke'; 'can I get out of the bed'; 'can I wear outdoor clothes in the ward'; 'what is the name of my nurse'; 'what can and can't I do'; 'how to contact relatives'; 'if mobiles can be used'; 'how to use Hospedia;'

No questions

Do you require any assistance to understand information e.g. Family / other Yes ☐ No ☐

Leaflets / written: Yes ☐ No ☐

Personalised Contact

As much as possible, try to be flexible about the timing of interventions to meet the patients personal needs. *Example questions of this could be, Would it be ok if we check on you every 1-2 hours to check you are ok or if you need anything?*

Nothing about you without you

Whilst you are in the ward we will involve you in any decisions regarding your care and discuss any referrals with you.

Nurse Initials TP Date 14/8/18

Personal Details

Personal Details

Home Circumstances

Home circumstances on admission

Do you have a carer: Yes ☐ No ☑

If yes: Family ☐ Private ☐

Do you live:-

Alone Yes ☐
With dependent partner ☐
With independent partner / family ☐
Does carer require additional support (Consider referral to social work) ☐

Are you a carer? Yes ☐ No ☐

Who for:

Children ☐ Elderly relative ☐ Other ☐

Please specify: .....

Who is caring for them currently?

Family ☐ Social Worker ☐
Nursing Home ☐ Neighbour ☐
Respite Centre ☐ Other ☐

Please specify:

Describe Family Living Arrangements

(Maisonette)

Type of House Up & downstairs house

Steps at entrance ☑ How many? 12

Stairs inside ☑ How many? 13

Toilet: Upstairs ☐ Downstairs ☐

Bedroom: Upstairs ☐ Downstairs ☐

Banister ☐ Others .....

.....

Comments

lives alone.

Community Services in Use		Frequency	Informed of Admission	Informed By / Comments
Home Care provided	Yes ☐ No ☑		Yes ☐ No ☐	
Meals on Wheels	Yes ☐ No ☑		Yes ☐ No ☐	
Sheltered Housing	Yes ☐ No ☑		Yes ☐ No ☐	
Day Hospital	Yes ☐ No ☑		Yes ☐ No ☐	
Community Nurse	Yes ☐ No ☑		Yes ☐ No ☐	
Community Psychiatric Nurse	Yes ☐ No ☑		Yes ☐ No ☐	
Learning Disability Nurse	Yes ☐ No ☐		Yes ☐ No ☐	
Visited by Specialist Nurse	Yes ☐ No ☐		Yes ☐ No ☐	
Specify:			Yes ☐ No ☐	

Functional Assessment of Medication Use: **Complete for all patients**

Pre-Admission Status

Independent ☑ Prompting required ☐ Assistance required ☐

Level ..... MAR Chart ☐ Compliance aid ☐ .....

On Admission Initial Assessment

Independent ☑ Prompting required ☐ Assistance required ☐

Level ..... MAR Chart ☐ Compliance aid ☐ .....

Do community nurses assist in medicine administration? Yes ☐ No ☐

If Yes, please provide details e.g. insulin administration .....

.....

Nurse Initials: ..... Date: .....

Nurse Initials: ..... Date: .....

Nurse Initials: ..... Date: .....

Nurse Initials: ..... Date: .....

Remember to re-assess patient needs and service requirements pre-discharge

Multi-Disciplinary Discharge Plan

To ensure safe and timeous discharge planned in partnership with the patient/carer and staff.

PATIENTS SHOULD BE CONSIDERED FOR CRITERIA LED DISCHARGE IF USED APPLY STICKER TO MDT DISCHARGE SUMMARY.

Write or attach label

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

Estimated discharge date:..... Medically fit date:..... Ready for discharge: .....

Date & Time	Reason for EDD change	New EDD	Initials

Discharge planning should be commenced on the day of admission

Date		Yes	No	N/A	Int
	Does the patient require a discharge planning meeting?				
	If yes to the above contact patient, family, social work and members of the MDT Record date of meeting...../Outcome.....				
	Discuss, document and agree discharge plan with patient, relatives, carers and MDT				
	Equipment needed. **Please document on checklist over page.**				
	Does the patient have house keys Key safe number:				
	Does the patient have appropriate clothing for discharge				
	Does the patient require a **Fit Note**				
	Has the patient been given a **Fit Note**				
	Does the patient require a home visit or environment assessment				
	Continuing care at home	Yes	No	N/A	Int
	Referred to ICES☐ Homecare☐ Occupational Therapy☐ Physiotherapy☐				
	Homecare referral type New referral☐ Increase☐ Restart☐				
	Level of Homecare Package				
	Homecare confirmed by..... Start Date & Time.....				
	Community nurse referral made ☐ Referred to Podiatry ☐				
	Discharge Medication/Aids	Yes	No	N/A	Int
	Order discharge prescription **(Consider Blister pack or MAR chart)**				
	Discharge prescription is on the ward				
	7 day supply of dressing, continence aids, catheters or stoma products (new patients must be given a 7 day supply and refer to district nurse for re-assessment)				
	Nutritional Supplements/Enteral Feed/Thickener: new patients must be given a 7 day supply				
	Transport Those able to make their own travel arrangements should be encouraged to do so	Yes	No	N/A	Int
	Own transport arrangements:				
	Hospital transport booked. Ambulance ☐am ☐pm **Reference No:**				
	Discharge Lounge	Yes	No	N/A	Int
	Is the patient suitable for the discharge lounge (Ext XH 26467 / 8) (Ayr 17078)				
	Plans in place to facilitate morning discharge **If no document why**				

MDT Discharge Plan

	Final checklist · Please complete all sections of this checklist on discharge	Yes	No	N/A	Int
	Cannula removed				
	Patients own medication returned				
	Discharge prescription given and explained to patient/carer				
	Clinic follow up arrangements given. (Please record in discharge summary)				
	7-days dressing supply provided				
	Patients property packed and valuables returned				
	If DNACPR keep copy in patients notes and send original home				
	Send home "Getting to Know Me" document if appropriate				
	Anticipatory Care Pathway or any other relevant community plan/pathway?				
	Inform family/NOK/carer when patient leaves the ward (If appropriate)				
	If appropriate the patient and their carer are provided with the NHS Preventing Pressure Ulcers: A guide for Adults at risk of Pressure Ulcers leaflet.				

MDT Discharge Plan

Equipment needs; essential equipment should be in place for discharge				
Equipment type	Date Requested	Arranged by	Expected delivery date	Delivery confirmed
Physio (specify)				
OT (specify)				
Commode				
Community electric profiling bed frame				
Pressure Reducing Mattress*				
Chair Cushion				
Foot protectors				
Wheelchair				
Oxygen Cylinder and/or Concentrator				
Enteral Feeding Equipment				
Community alarm				
Key safe				
Other (specify)				

* Please call the district nurse to discuss before ordering.

Multi-Disciplinary Discharge Summary

Date & Time	This should include reference to SSA, 24hr continuing care or rehab	Initials
16/8/18	Pt awaits meds and transport	
	via DCL	AH
15[15]	Ambulance staff arrived to	
	take pt and he left	
	disgruntled due to meds	
	not being ready. Left	
	ward	M

MDT Discharge Plan

MDT Discharge Plan

Multi-Disciplinary Discharge Summary

Date & Time	This should include reference to SSA, 24hr continuing care or rehab	Initia

Lifestyle Assessment/Usual Ability

Please add date, time & signature when you update the Lifestyle Assessment

Date/time..... Sign .....

Date/time..... Sign .....

Date/time..... Sign .....

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Pre-admission Status
Communicating

Any specific communication needs:

Speaking	Yes ☐	No ☐
Reading	Yes ☐	No ☐
Writing	Yes ☐	No ☐
Glasses	Yes ☑	No ☐
Contact Lenses	Yes ☐	No ☐

Hearing aid - Left ☐ with Patient ☐
Hearing aid - Right ☐ with Patient ☐

Initial assessment
Detail Presenting Problems/Risk/Needs

Interpreter required** Yes ☐ No ☐

No issues on arrival.

Breathing

Do you normally have any issues with breathing?
Yes ☐ No ☐
If yes, please describe..... Asthma (childhood). Not on inhalers.

Equipment / aids - circle all that apply: Inhalers / oxygen -concentrator / cylinder / nebulisers / tracheostomy.

Do you smoke? Yes ☑ No ☐

If so how many.....

All smokers *must* be referred to Fresh Air-shire for discussion about smoking management whilst in hospital; this will include being advised about the current smoking policy. Please attach a patient sticker to referral card and place it in the Fresh Air-shire referral box on the ward. For any queries please phone Fresh Air-shire on 08007 839132.

Please tick when this referral has been made ☑

Date & time of referral..... 14/6/14

Detail Presenting Problems/Risk/Needs

Patient wishes nicotine replacement therapy?
Yes ☐ No ☐

Should a patient insist on leaving the ward for a cigarette, a smoking disclaimer must be completed.

Smoking disclaimer signed Yes ☐ No ☐

Mobilising/Falls Risk Assessment

Does the patient normally have a reduced functional ability	Yes ☐	No ☑
Walking aids	Yes ☐	No ☑
Pain	Yes ☐	No ☑
Foot Problems	Yes ☐	No ☑
Poor balance	Yes ☐	No ☑
Uncoordinated movements	Yes ☐	No ☑
Medication that could increase risk	Yes ☐	No ☑
Falls History	Yes ☐	No ☑
Cognitive Impairment	Yes ☐	No ☐
Sensory Problems	Yes ☐	No ☐
Is patient at risk of falling from bed?	Yes ☐	No ☐

Detail Presenting Problems/Risk/Needs

Independent

Is the patient at risk of falls?* Yes ☐ No ☐

* Consider increasing frequency of care and comfort rounding
* Consider higher level supervision policy
** Language Line 0845 310990 ID No L28656

Lifestyle Assessment

Lifestyle Assessment

Lifestyle		Yes	No
Driving Status	Do you Drive	☐	☑
Physical Activity	How many days per week do you usually undertake a total of 30 minutes or more exercise? 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ NA☐ If less than 5 days, does this equal more than 2½ hours of activity a week	☐	☐
Alcohol Use	Units per week 21 Pints gin per day will drink anything Suitable for alcohol brief intervention? ☐ Not applicable Currently in Treatment? ☐ Not applicable Refer to alcohol liaison team? ☐ Not applicable	☐ ☐ ☐	☐ ☐ ☐
Substance misuse	Substance misuse issues/? If yes give details: Currently in treatment? ☐ Not applicable Refer to substance misuse? ☐ Not applicable	☐ ☐	☐ ☐

Pre Admission Status	Initial assessment
Eating and Drinking	**Detail Presenting Problems/Risk/Needs**
Date..... Time ..... Does the patient need assistance in carrying out their own basic oral care? Yes☐ No☑ Does the patient have dentures? Yes☐ No☐ Top☐ Bottom☐ Partial☐ With Patient☐ Is the patient suffering from mouth pain? Yes☐ No☐	Independent.
Patient on nutritional supplements / enteral feed at home? Yes☐ No☑ Type: _____ Amount _____ Frequency _____ kitchen notified Yes☐ No☑ Any changes in eating pattern/appetite? Yes☐ No☑ Specify: _____ Support required for eating/drinking? Yes☐ No☑ Equipment required to support eating /drinking Yes☐ No☑ ***Likes*** _____ ***Dislikes*** _____ Long term swallowing ability impaired (Consider referral to SLT) Yes☐ No☑ Modified Diet/Fluids Texture..... Stage..... Consent to therapeutic diet (Cultural/Ethic/Religious requirements) Yes☐ No☑ Complete MUST Screening on page 20.	Poor appitte. but doesnt have any concens thats Patients Norm. ?11.st 4.
Eliminating	**Detail Presenting Problems/Risk/Needs**
Normal bowel habit Yes☑ No☐ When did your bowels last move? ..... Any problems passing urine? Yes☐ No☑ Does the patient have a urinary catheter in situ Yes☐ No☐ Date of catheter insertion _____ Long term catheter? Yes☐ No☐ Complete continence assessment if required Refer to Adult Continence Assessment Pathway algorithm	If YES apply the Catheter Care Bundle Referral Date: _____

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Pre Admission Status	Initial assessment
Personal Cleansing & Dressing	**Detail Presenting Problems/Risk/Needs**
Is patient normally independent? Yes ☑ No ☐ What type of assistance is required by the patient (please consider patient preferences)	
Skin Condition PPURA	**Detail Presenting Problems/Risk/Needs Preliminary Pressure Ulcer Risk Assessment (PPURA)**
Date 13/8/18 Time 14.00 **Mobility** Patient is fully mobile without equipment / assistance Yes ☑ No ☐ **Continence** Patient is fully continent Yes ☑ No ☐ **Nutrition** Patient appears to be well nourished and able to eat and drink Yes ☑ No ☐ **Skin** Skin is healthy and intact Yes ☐ No ☑	Assess condition of skin, any wounds / lesions / stomas Patient states skin is intact. If **No** to any questions undertake Waterlow Assessment and apply the SSKIN bundle if indicated. If all answers Yes complete a daily PPURA see page 18
Spiritual or religious needs	**Detail Presenting Problems/Risk/Needs**
Faith or Life Stance? Nil Do you have any spiritual or religious needs whilst in hospital? *(please state)* Yes ☐ No ☑ Do you wish your details passed to the hospital Chaplaincy Service? Yes ☐ No ☑ Do you wish your own Minister/Priest contacted Yes ☐ No ☑ If yes complete name & telephone number Name..... Tel No..... Specify needs or cultural practices that place limitations on the patient's care *(please state)*	

Preliminary Pressure Ulcer Risk Assessment (PPURA)

Complete or attach addressograph
HCR No:
CHI No:
Surname:
Forename: Sex:
Address:

Points to consider

- Use within 6 hours of admission to care area
- Use daily if the person is identified to be 'not at risk'
- People who are overweight may not be well nourished
- Please sign after each check

Mobility:	Person is fully mobile without equipment/assistance
Continence:	Person is fully continent
Nutrition:	Person appears well nourished and able to eat and drink
Skin:	Persons pressure areas are healthy, with no signs of redness, discolouration, including bruising or ulceration.

Record your answer in the grid below **Y** – Yes or **N** – No
If the answer is **Yes** to all statements use this chart daily
If the answer is **No** to any statement undertake a full pressure ulcer risk assessment and consider any other relevant assessment

Date	Time	Mobility	Continence	Nutrition	Skin inspected	Is a full pressure ulcer risk assessment required?	Signatu

Patient Risk Assessment

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After completing the Individual Person Centred Lifestyle Assessment please now decide which risk assessments your patient needs.

In some circumstances your professional judgement may decide that this patient is exempt from a particular mandatory assessment. You must clearly document the reason for this decision.

Identify relevant assessment tools and tick the box to confirm assessment tool activated.

Yes	N/A		
☐	☑	**MRSA**	**mandatory**
☐	☑	**Nutrition - MUST**	**mandatory**
☐	☑	**Oral Health**	**initial rapid assessment questions mandatory if clinically indicated**
☐	☑	**Pressure Area Care - Waterlow**	**Mandatory if PPURA indicates needs**
☑	☐	**4AT**	**all patients over 65 or if patient has a suspected delirium**
☑	☐	**Bedrails**	**mandatory**
☑	☐	**Moving and Handling**	**mandatory**
☐	☐		

You may use your professional judgement to decide which assessment tools are most relevant to your patient. It may not be necessary to complete all risk assessments for every patient.

Not Completed		Reason Why
☑	**MRSA**	No Issues
☑	**Nutrition - MUST**	No Issues.
☑	**Oral Health**	Independent
☑	**Pressure Area Care - Waterlow**	Independent
☐	**Falls**	
☑	**Bedrails**	Independent
☑	**Moving and Handling**	Independent
☑	**4AT**	No issues.

It will be necessary to re-assess the requirement for completion of the above risk assessments during the patients stay

Nurse Initials: [illegible] Date: 13/

Risk Assessment

Risk Assessment

NHS Ayrshire & Arran

Infection Prevention & Control Assessment

⚠ You MUST CHECK PMS for details where you see this symbol

Complete or attach addressograph

HCR No: .....

CHI No: .....

Surname: .....

Forename: ..... Sex: .....

Address: .....

MRSA Clinical Risk Assessment (CRA) You MUST CHECK PMS for details where you see this symbol ⚠

ALL PATIENTS MUST HAVE CRA COMPLETE FOR PRE-EMPTIVE ISOLATION PURPOSES

	Yes	No	Action to be taken
Has the patient had any **previous history of MRSA** colonisation or MRSA infection at any time in the past? ⚠ **CHECK PMS**		✓	**After checking PMS ⚠ if you have answered NO to all** three of the questions **then** no further action is required in all non-high risk areas
The patient currently **resident in a care home or institutional setting** (i.e. prison, homeless hostel) or **transferred from another hospital (including those within Ayrshire)?**		✓	**If you have answered 'Yes' to any** of the three questions or your ward is one of the high risk specialties detailed above you **MUST** • Swab **nose and perineum** (& wound or device where applicable) for MRSA
Does the patient **have a wound/ulcer or indwelling medical device** which was present before admission to this hospital?		✓	**If you have answered 'Yes' to any of the three questions regardless of specialty** • Manage patient as if MRSA positive (refer to MRSA Policy) **Date swabs obtained** ..... **Print name**.....

Gastro intestinal risk assessment for CID, norovirus and other gastro-intestinal infections

	Yes	No	Action to be taken
Is the patient presenting at admission with diarrhoeal stool (Bristol stool chart 5, 6, 7) and/or vomiting		✓	**If YES – implement Transmission Based Precautions and isolate patient.** Initiate weekly Bristol stool chart. Send sample to the laboratory. **Date sample sent** ..... **Print name**.....
Has been transferred from any ward/nursing home with suspected or confirmed cases of norovirus.		✓	

Multi drug resistant organism e.g. Carbapenemase-producing Enterobacteriaceae (CPE)

	Yes	No	Action to be taken
Has the patient been • transferred from a hospital outside Scotland • hospitalised outside Scotland in the last 12 months? • Received holiday dialysis outside Scotland • Been a close contact with a person who has been colonised or infected with CPE		✓	**After checking PMS ⚠ if you have answered NO to all** the questions then there is no further action to be taken. If you have answered **YES** to any of the questions you **MUST** screen the patient this includes • Swabs from the **rectum** (& wound or device where applicable) • Manage patient as if CPE positive (refer to CPE Policy) • Inform a member of the Infection Prevention and Control team
⚠ Has the patient been previously positive for CPE at any body site? **(Check case notes and lab results in addition to PMS)**			**NOTE:-IN THE INVESTIGATIONS BOX ON THE LABORATORY REQUEST FORM YOU MUST REQUEST "CPE SCREENING".** **Date swab obtained**..... **Print name**.....

For further advice if required contact the Infection Prevention & Control Team (ext 25765) or the on-call Consultant Microbiologist (via switchboard).

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to be weighed

Nutritional Screening 'Malnutrition Universal Screening Tool' ('MUST')

Food Fluid and Nutrition

Step 1: Measure height and weight to get a BMI score.
Step 2: Note percentage unplanned weight loss and score.
Step 3: Establish acute disease effect and score.
Step 4: Add scores from steps 1, 2 and 3 together to obtain overall risk of malnutrition.
Step 5: Follow the management guidance appropriate to the risk category and commence the corresponding care plan.

Screening Results

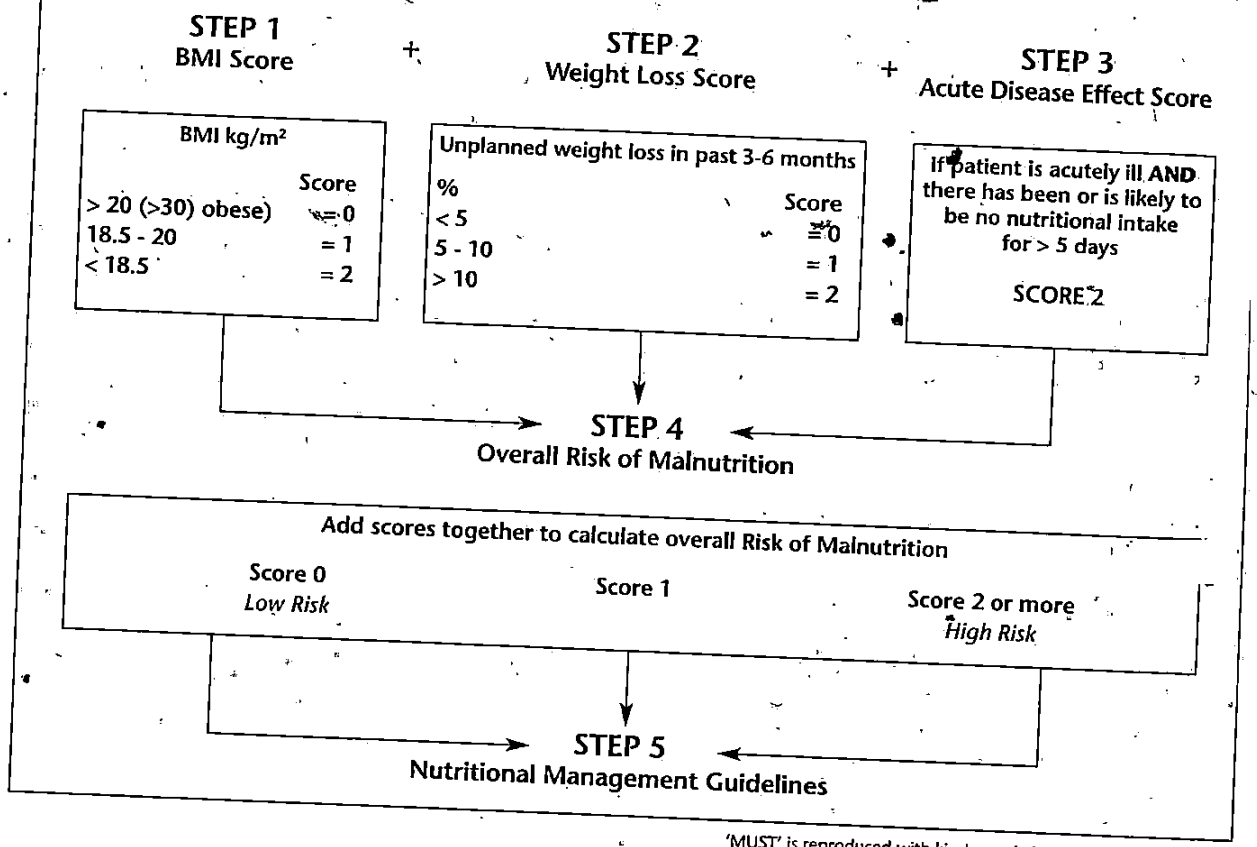
Please indicate if measurements are Measured (M), Reported (R) or Estimated (E)

Date	13/8/17				
Time	14-20				
Ward	CAU				
Height (metres) (M) (R) (E)	5'5" m	m			
Current weight (Kg) (M) (R) (E)	70 Kg ( )	Kg ( )	Kg ( )	Kg ( )	Kg ( )
BMI	25				
Is patient within obese category?	NO				
Usual weight (Kg)	— Kg				
Signature	[signature]				
MUST					
Step 1: BMI Score >20 (>30 = Obese) ..... 0 18.5 - 20 ..... 1 < 18.5 2	0				
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months. <5% ..... 0 5 - 10% ..... 1 >10% 2	0				
Step 3: Acute Disease Effect Score If patient is acutely ill and there has been or is likely to be no nutritional intake for>5 days.....Score 2 Not applicable .....Score 0	0				
Step 4: Overall Risk of Malnutrition Total:	0				
Step 5:	0 = Low Risk	1 = Medium Risk	2 or more = High Risk		

Referrals	Consent for referral obtained	Date referred	Signature
Dietician	☐		
Speech and Language Therapy	☐		

Risk Assessment

MUST Screening



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Nutritional Management Guidelines:

MUST Score 0	MUST Score 1	MUST Score 2 or more
Low risk - *Routine Clinical Care*	**Medium risk** - *Observe*	**High risk** - *Treat**
• Commence and implement the **Low Risk Care Plan**	• Commence and implement the **Medium Risk Care Plan**	• Commence and implement the **High Risk Care Plan**
• Monitor and review care plan	• Monitor and document dietary intake whilst in ward/department on a Food Record Chart	• Refer to Dietitian, include MUST scor
• **Repeat screening as below:**	• Encourage oral intake	• Continue to monitor dietary intake.
Acute..... weekly	• Assist patient to choose appropriate meals/snacks and offer milk or suitable alternative to drink with and between meals.	• Offer maximum encouragement.
Continuing Care..... monthly	• Provide nutrition information leaflet to patient.	• Monitor and review care plan
	• Monitor and review care plan	• Repeat screening weekly or when next in department.
	• **Repeat screening weekly or when next in department.**	• Consider use of red tray/jug
		*Unless detrimental or no benefit is expected from nutritional support e.g. imminent death. Use own judgement and document rationale for not treating.

- For low risk patients implement interventions in the **green** section of the care plan, as appropriate.
- For medium risk patients implement interventions in the **green** and sections of the care plan.
- For high risk patients implement interventions in the **green,** and **red** sections of the care plan.
- Always use your own professional judgement when screening patients and making referrals.
- Consider initial admission information relating to eating and drinking needs and preferences.
- When completing Step 2 always compare the most recent weight with the 'usual' weight (or use the initial weight taken on admission if necessary) and not the previous weeks weight.

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Malnutrition Universal Screening Tool ('MUST') Multidisciplinary Care Plan

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Patient Problem
Nutritional screening has identified the patient as being Low ☒ Medium ☐ High ■ Risk of malnutrition
Patient identified as having other nutritional problems e.g. obesity, chewing certain foods (specify)

Goal
To meet patients nutritional and fluid requirements

Date	Time	Intls	Planned Nursing Interventions/Support	End Date	Intls
			Low Risk Care Plan		
13/2/18	14.30	TP	Assistance required (specify) e.g. helping, prompting, cutting up food, opening packets:-		
			Individual / therapeutic dietary requirements (specify) e.g. likes/dislikes religious/ethical/cultural:-		
13/2/18	1430	TP	Modified eating equipment (specify) e.g. cutlery.		
			Assist patient to select appropriate meals from menu card.		
13/2/18	14.30	TP	Ensure fresh drinking water is offered regularly and available at all times, where clinically appropriate.		
			Consider patients positioning and support oral hygiene, if required.		
			Ensure patients nutritional needs recorded on nutrition board.		
13/2/18	1430	TP	Monitoring and review care plan **repeat screening weekly** (monthly continuing care).		
			Medium Risk Care Plan (complete low risk section also)		
			Commence food chart for a minimum of 3 days. Only discontinue if/when dietary intake is adequate.		
			If intake is insufficient, offer patient milk to drink with / and between meals and suitable additional snacks.		
			Record accurate fluid intake / output on fluid balance chart until established that oral intake is adequate. If intake per 24 hours is inadequate consider IV/SC fluids.		
			Monitor and review care plan and **repeat screening weekly.**		
			RED TRAY Yes ☐ No ☐ RED JUG Yes ☐ No ☐		
			High Risk Care Plan (complete low and medium risk section also)		
			Refer to Dietitian, ensuring the MUST score is included.		
			Discontinue food chart only when advised by Dietitian.		
			Administer and monitor enteral feed via NG/PEG route as per local guidelines.		
			Monitor and review care plan and **repeat screening weekly.**		
			This care plan has been discussed and agreed with the patient as appropriate.		

Risk Assessment

Risk Assessment

Following assessment the Speech and Language Therapist will recommend which texture is suitable for the Individual	
Modified Food Consistency	
Texture B Thin Puree	Smooth consistency with no lumps Can be poured Will slowly drop through prongs of a fork **Thick enough to stand a light plastic teaspoon in**
Texture C Thick Puree	Smooth, moist consistency with no lumps and should not be sticky on palate Cannot be poured Holds its shape on the plate when scooped **No separation of fluids**
Texture D Pre-mashed	Mashed or finely minced before serving Very soft, tender and moist Needs very little chewing **No mixed textures or separation of fluids**
Texture E Fork Mashable	Food must be able to be mashed with a fork Soft, tender and moist Needs some chewing **Meat must be very soft and tender, or minced in thick sauce**

Modified Fluid Consistency	
Stage 1 **Syrup consistency**	Use 1 level scoop of Nutilis Clear in a 200ml drink • This leaves a thin coat on the back of a spoon
Stage 2 **Custard consistency**	Use 2 level scoops of Nutilis Clear in a 200ml drink • This leaves a thick coat on the back of a spoon
Stage 3 **Pudding consistency**	Use 3 level scoops of Nutilis Clear in a 200ml drink • This needs to be taken with a spoon • This will be too thick to drink from a cup

Please record any Therapeutic/Special Diet/Fluids

Texture/Stage/Type (include diabetic, gluten free etc)	Date commenced	Comments	Date discontinued

Please Record if Patient on / Commenced on Supplements
If on supplements please commence supplement monitoring chart

Supplement	Frequency	Any preferences / dislikes	Supplement Chart	On Nutrition Board	Stopped

Any additional interventions (free text)

Further information can be found in the Dietetic Treatment Record

Oral Health Risk Assessment

Rapid Assessment Questions		Circle which is appropriate		Suggested outcome/actions if "Yes" circled
Does the patient need assistance in carrying out their own basic oral care?		Yes	No	If you have answered yes to any of these questions please complete full oral health risk assessment below and review 4-weekly
Does the patient need assistance taking care of their dentures?		Yes	No	
Is the patient suffering from mouth pain?		Yes	No	
What is your normal mouth care routine at home? (for initial assessment only)				Details
Are you having any problems with your teeth or mouth?				Details
Patient Assessment		**Circle which is appropriate**		**Suggested outcome/actions if "Yes" circled**
Smoking habits	Smoker? (which may increase risk of gum disease and oral cancer?	Yes	No	Note amount per day on profile Consider smoking cessation
Dexterity problems	Having difficulty holding toothbrush?	Yes	No	May need supervision/help with mouth care Consider OT adaptation
Cognitive function	Evidence of short-term memory loss and/or confusion?	Yes	No	May need supervision/help with mouth care
Oral Assessment - use tongue compressor and pen torch to examine oral cavity		**Circle which is appropriate**		**Suggested nursing care If "Yes" circled**
Lips	Dry/cracked?	Yes	No	Apply an emollient e.g. lubricating gel
Tongue	Dry/coated?	Yes	No	Clean with soft toothbrush and toothpaste Offer frequent fluids
	Evidence of ulceration/soreness?	Yes	No	If yes, refer to Public Dental Services (PDS)* or advise patient to contact their dentist on discharge
Gums / soft tissue	Evidence of soreness, ulceration, bleeding gums or whiteness?	Yes	No	If yes, refer to PDS* or advise patient to contact their dentist on discharge
Saliva	Dry mouth? (xerostomia) could be side-effect of medication e.g. antidepressants, anticonvulsants etc.	Yes	No	Offer frequent fluids and/or iced water If symptoms persistent refer to dentist
Teeth	Natural top teeth?	Yes	No	Encourage independence with cleaning teeth night and morning. Use toothbrush and fluoride toothpaste (see Basic Oral Care Guidelines for concentration of fluoride)
	Natural lower teeth?	Yes	No	
	Evidence of plaque / debris?	Yes	No	Supervise/help with oral care Use toothbrush and fluoride toothpaste
Dentures	Top denture?	Yes	No	Supervise/help with cleaning dentures night and morning with mild soap and water; rinse dentures after meals. Clean teeth as above Remove dentures at night and leave to soak in water with Milton
	Lower denture?	Yes	No	
	Dentures and natural teeth?	Yes	No	
Pain	When eating/drinking?	Yes	No	If yes, refer to PDS* or advise patient to contact their dentist on discharge
	Caused by teeth/dentures?	Yes	No	
Swallowing	Difficulty with swallowing?	Yes	No	Supervise/help with cleaning teeth and/or dentures and oral cavity after each meal
Nutrition	NBM / Fluid/dietary intake poor?	Yes	No	May require 2 hourly mouth care Check whether oral problems contributing
	Dehydrated?	Yes	No	
	On energy-dense diet or prescribed supplements/snacks?			Consider high fluoride toothpaste if have natural teeth (2800ppm F)

Signed: .....

Date and Time: .....

* Dental Services Helpline: 01563 507 950

For urgent care or advice on weekdays

NHS 24: 111

For dental emergencies out-of-hours

Risk Assessment

Risk Assessment

Oral Hygiene - Care Plan

Write or attach label

HCR No:.....
CHI No:.....
Surname:.....
Forename:..... Sex:.....
Address:.....
.....
Date of Birth.....

Pre Admission Status

Patient has undergone oral assessment and requires assistance with regular mouth care

Goal

For oral cavity to be clean, pink, moist and comfortable

Date	Time	Init's	Planned Nursing Interventions	Discontinued Date/Time	Initi
			Dental Referral		
			• If patient hasn't seen a dentist • If patient suffers from mouth pain • If evidence of ulceration/soreness on tongue • If evidence of ulceration, bleeding gums or whiteness in gums/soft tissues		
			Oral Care		
			If patient is able, prompt by providing adequate opportunity and support to carry out oral care.		
			If patient is dependent, ensure mouth care is offered and provided at regular intervals.		
			If patient has dentures supervise/help with cleaning them night and morning with mild soap and water; rinse dentures after meals. Dentures should be left out and soaked in sodium hypochlorite overnight or for at least 20 minutes, before rinsing and leaving in plain water for the rest of the time. Metal-based dentures should be soaked in chlorhexidine mouthwash.		
			Other Issues		
			If lips are dry apply emollient e.g. lubricating gel.		
			If tongue is dry and coated clean with soft toothbrush and toothpaste and offer frequent fluids.		
			If patient suffers from dry mouth offer frequent fluids and/or iced water. If symptoms persist refer to dentist.		
			If patient has difficulty swallowing you should supervise/help with cleaning teeth and/or dentures and oral cavity after each meal.		
			If patient is nil by mouth or has poor fluid or dietary intake or is dehydrated they may require 2-hourly mouthcare. Check whether oral problems contributing.		
			If patient is on an energy dense diet or prescribed supplements/snacks consider high fluoride toothpaste if have natural teeth.		
			This care plan has been discussed and agreed with the patient as appropriate.		

NHS Ayrshire & Arran

Adapted Waterlow Pressure Area
- Risk Assessment Chart

More than one score can be used in each section

Complete assessment according to PPURA or if there is a change in individual's condition and repeat regularly according to local protocol

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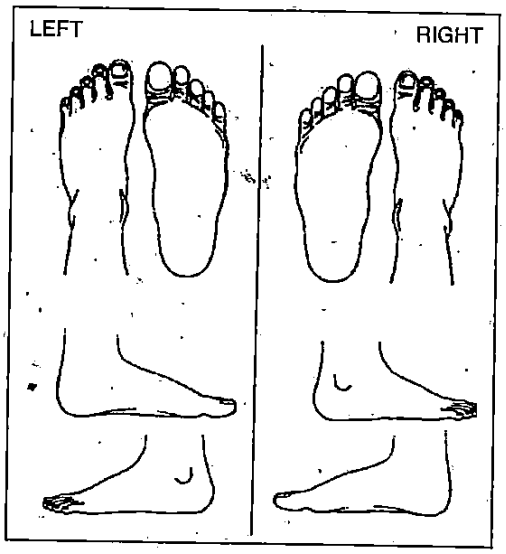
		Date	13/8/15	16/8									
		Time	14:35	04:16									
Sex													
Male 1 Female 2			1	1									
Age													
14 - 49	1												
50 - 64	2		2	2									
65 - 74	3												
75 - 80	4												
81+	5												
Build/Weight for Height *(BMI=weight in Kg/height in m²)*													
Average - BMI 20-24.9	0												
Above average - BMI 25-29.9	1		0	0									
Obese - BMI > 30	2												
Below average - BMI < 20	3												
Continence													
Complete/catheterised	0												
Urinary Incontinence	1		0	0									
Faecal incontinence	2												
Urinary and faecaly incontinent	3												
Skin Type - Visual Risks Area													
Healthy	0												
Tissue paper (thin/fragile)	1		0	0									
Dry (appears flaky)	1												
Oedamatous (puffy)	1												
Clammy (moist to touch) pyrexia	1												
Discoloured/Bruising/Grade 1	2												
Broken (established ulcer) Grade 2 - 4	3												
Mobility													
Fully mobile	0												
Restless/fidgety	1		0	0									
Apathetic (sedated/depressed/reluctant to move)	2												
Restricted (restricted by severe pain or disease)	3												
Bedbound (unconscious/unable to change position/traction)	4												
Chairbound (unable to leave chair without assistance)	5												
Special Risks - Tissue Malnutrition													
Multiple organ failure/terminal cachexia	8												
Single organ failure e.g. cardiac, renal, respiratory	5												
Peripheral vascular disease	5												
Anaemia = Hb < 8	2		1	1									
Smoking	1												
Special Risks - Neurological Deficit													
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6		0	0									
Special Risks - Surgery/Trauma													
On table > 2 hours (up to 48 hours post op)	5												
On table for up to 6 hours (up to 48 hours post op) provided the rate of recovery is normal)	5												
Orthopaedic/below waist/spinal	8			-									
Special Risks - Medication													
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4			-									
		Total Score	4	4									
		Initials	TR	LD									

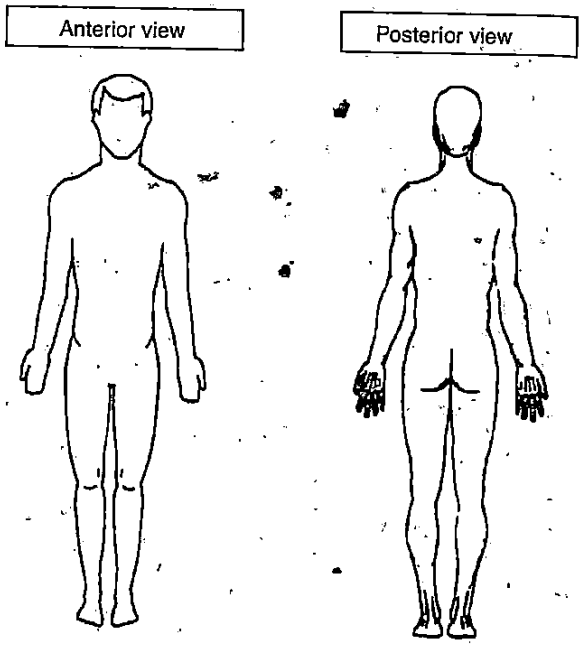
<10 Low Risk - Reassess weekly 10+ At Risk - Reassess twice weekly 15+ High Risk - Reassess on alternate days 20+ Very High Risk - Assess daily	▫ The Waterlow **must be reassessed** if the patient's condition changes /deteriorates and the plan of care should be reviewed at that point. • For patients who are in long term care, provided their condition is stable after one week of admission the Waterlow can be reassessed weekly/monthly

Risk Assessment

Pressure Ulcer Record

Indicate by circling, numbering and dating all pressure damage on diagrams, then complete box below. Initiate SSKIN care plan/wound assessment chart.





Date	Number of ulcer	Location of ulcer	Grade of ulcer	Datix Insert reference Grade 2-4	Logged on safety cross Grade 1-4	Signature	Print name

Scottish Adapted European Pressure Ulcer Advisory Panel) EPUAP - Pressure Ulcer Grading Tool - 2014

GRADE 1 Intact skin with non blanchable redness, usually over a bony prominence. Darker skin tones may not have visible blanching but the colour may differ from the surrounding skin. The area may be painful, firmer, softer, warmer or cooler than the surrounding tissue.

GRADE 2 Loss of epidermis/dermis presenting as a shallow open ulcer with red/pink wound bed without slough or bruising. May also present as a blister.

GRADE 3 Subcutaneous fat may be visible but bone tendon or muscle is not visible or palpable. Slough may be present but does not obscure the depth of tissue loss. Often includes undermining or tunnelling

GRADE 4 Extensive destruction with exposed or palpable bone, tendon or muscle. Slough may be present but does not obscure the depth of tissue loss. Often includes undermining or tunnelling.

DEEP TISSUE INJURY Epidermis is intact but the area appears purple or maroon or is a blood filled blister over a dark wound bed. Over time the skin will degrade and develop into deeper tissue loss.

UNGRADABLE: Full thickness skin loss where the depth of the ulcer is completely obscured by slough/necrosis. Until enough slough or necrotic tissue is removed to expose the base of the wound the true depth cannot be determined. It may be a grade 3 or 4 once debrided.

All acquired pressure ulcers graded 2 - 4 must be reported via Datix.
Refer to podiatry for at risk feet.

Falls for All Bundle

Please complete for all patients on admission

Write or attach label

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

1. 5Q's
   a. Has the patient fallen in the last 6 months – including during this admission? Yes ☑ No ☐
   b. Does that patient have cognitive impairment or possible delirium? Yes ☐ No ☑
   c. Does that patient attempt to walk alone although unsteady or unsafe? Yes ☑ No ☐
   d. Does the patient or their relative/s have fear or anxiety, Re falling? Yes ☐ No ☑
   e. Based on your clinical judgement, is this patient at high risk of falling? Yes ☑ No ☐

If yes to any of the above, the patient is deemed as a vulnerable patient and should be commenced on the more vulnerable falls bundle (recording of this is included in care and comfort rounding or alternatively should be recorded in the patients records).

Initials: JP

Date: 13/8/17

Time: 14:35

Risk Assessment

Risk Assessment

Slips Trips & Falls - Care Plan

(To be used in conjunction with the falls for all bundle)

Problem Number:

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

Patient Problem/Need
Patient is considered to be at risk of falling

Goal
To promote and maintain patient safety and reduce the risk of falls

Date	Time	Initial	Planned Nursing Interventions	Discontinued Date/Time	Initial
13/8/18	1430	TP	Orientate patient and family/carers to ward environment on admission and each shift.		
13/8/18	1430	TP	Ensure buzzer within reach.		
13/8/18	1430	TP	Explain importance about calling for help when needed.		
13/8/18	1430	TP	Ensure that bedside table and key belongings are within easy reach.		
13/8/18	1430	TP	Ensure patient wears appropriate clothing and footwear.		
13/8/18	1430	TP	Ensure that patient is wearing spectacles if appropriate.		
13/8/18	1430	TP	Discuss with family/carers how to assist with interventions.		
13/8/18	1430	TP	Ensure that patient/family receives an explanation of risk and the measures in place to minimise this risk and document outcome.		
13/8/18	1430	TP	Ensure that standard bed frame is used and left in a low position with brakes on.		
13/8/18	1430	TP	Select a chair that is the appropriate height and design for the patient (seek guidance from Physio and OT).		
13/8/18	1430	TP	When in use ensure that chair/commode brakes are secure.		
13/8/18	1430	TP	Ensure that area is illuminated appropriately at night time.		
13/8/18	1430	TP	Liaise with medical team re: medication review.		
13/8/18	1430	TP	Consider referral to Physiotherapy, Occupational Therapy, Social Work.		
			Monitor lying and standing blood pressure.		
			Supervise patient when transferring as per moving and handling risk assessment.		
			Supervise patient when mobilising as per moving and handling risk assessment.		

			Offer toileting facilities as appropriate.		
			Ensure that patient is cared for in an area proximal to toilet facilities, if possible.		
			Encourage family, if present, to sit with patient (as appropriate).		
			Encourage family/carers to report to nursing station when ending their visit.		
			Consider appropriate equipment in liaison with Physio and / or OT.		
			Ensure yellow sticker is inserted into patient's notes after each fall.		
			Patients who may be confused or have had repeated falls where possible should be cared for in an area within the ward that is within easy view of nursing staff.		
			Check on patient every 15 minutes.		
			Consider a higher level of supervision of the patient.		
			Consider the use of a low level variable height bed.		
			Above care plan has been discussed and agreed with the patient and / or family / carer		

Risk Assessment

NHS Ayrshire & Arran

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI458158

Bedrails Risk Assessment

Date of admission:..13/8/18.....

Please assess **ALL** patient on admission to your ward/departments

- Each statement must be answered - Circle answer
- Complete Risk Assessment in conjunction with Bedrails Algorithm overleaf
- Refer to Guidelines - Safe Use of Bedrails in In-patient Settings & Falls Prevention
- Ensure that you are aware of the safety requirements when using a bedrail, you have undertaken a visual check of the bedrail and that you are satisfied that there are not obvious areas of faults

Re Assessment Occurs

- Weekly
- When the patient's condition changes (i.e. patient falls/post surgery/change in medication/cognitive state changes)

Ensure clear identification of a change in use of bedrails within documentation and at bed space if consent obtained from patient

Risk Factors	Ward: CAU Date: 13/8/18 Time: 1440	Ward: 53 Date: 16/8/18 Time: 0410	Ward: Date: Time:	Ward: Date: Time:
1. Is the patient at risk of **falling** from bed?	~~YES~~ / NO	YES / (NO)	YES / NO	YES / NO
2. Is the patient at risk of **intentionally** climbing over the bedrails?	~~YES~~ / NO	YES / (NO)	YES / NO	YES / NO
3. Is the patient at risk of **unintentionally** falling from the bed/trolley?	YES / ~~NO~~	(YES) / NO	YES / NO	YES / NO
4. Does the patient **understand** the purpose of the bedrails? Consider communication difficulties and physical/Cognitive condition.	YES / ~~NO~~ / ~~NA~~	(YES) / NO / NA	YES / NO / NA	YES / NO / NA
5. Does the patient **consent** to the use of bedrails?	YES / ~~NO~~ / ~~NA~~	YES / (NO) / NA	YES / NO / NA	YES / NC / A
Has the Bedrails Algorithm been followed?	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
According to the Bedrails Algorithm are bedrails required / appropriate?	Yes ☐ No ☑	Yes ☐ No ☑	Yes ☐ No ☐	Yes ☐ No ☐
Bumpers required	Yes ☐ No ☑	Yes ☐ No ☑	Yes ☐ No ☐	Yes ☐ No ☐
Initials	TP	LD		

If Yes, commence a Safe Use of Bedrails Care Plan. If No, state reason why bedrails are not required.

Patient independent at present and currently no issues this may change if DTs worsen.

Bedrails Algorithm

Complete the NHS Ayrshire and Arran Slips Trips and Falls Assessment Tool

Is the patient at risk of falling from bed/trolley?
NB: for patients at risk of climbing over bedrails, alternatives must be considered. See boxes 2+3

Yes

Patient understands purpose of the bedrails

- Patient consents to bedrail use → Bedrails could be used with caution. See boxes 1 + 3 below
- Patient declines bedrail use → Bedrails inappropriate see boxes 2+3

Patient does not understand purpose of bedrails due to .....

- Communication difficulties → Consider:
  - Referral to appropriate speciality e.g. audiology
  - Use of interpreter
  - Use of written or pictoral information
- Physical and/or cognitive condition → Consider actions in patient's best interest. See boxes 1, 2 + 3 below → Agree plan of care with Next of Kin and document outcome in nursing records

No

- Patient requests bedrails → Bedrails could be used with caution. See boxes 1 + 3 below
- Patient not requesting bedrails → Bedrails inappropriate see box 3

1. If bedrails are used consider:

- Risk of entrapment and harm to limbs
- Risk of patient climbing over the top
- The psychological effect of their use on the patient
- Ensure bed returned to lowest height after care delivery
- Use of the Dynamic mattress increases the height of the bed

2. Alternatives to bed rails

- Use of variable height bed
- Additional mattress/crash mat beside bed
- Close observation of patient
- Ensure bed returned to lowest height after care delivery
- Ensuring patient needs anticipated e.g. drinks are accessible, regular toileting, call bell to hand etc
- Nursing patient on mattress on the floor should be a last resort and safety checks should be made for hot pipes, electric sockets etc. Manual handling risk assessment for staff must be undertaken

3. Remember to document in nursing records:

- Date and time assessment made
- Rationale for decision made in care plan
- Actions taken, including discussion with Next of Kin
- Care planning

Assessment should be made:

- On admission
- If patient's condition changes
- Weekly

Risk Assessment

Safe Use of Bed Rails - Care Plan

Write or attach label
HCR No:
CHI No:
Surname:
Forename: Sex:
Address:
Date of Birth

Patient Problem/Need
The patient is at risk of falling out of bed due to (e.g. cognitive or physical condition)

Goal
To promote and maintain patient safety and reduce the risk of falling out of bed

Date	Time	Initial	Planned Nursing Interventions	Discontinued Date/Time	Initial
14/8/19	1435	TP	Ensure assessment is made on admission, when patient's condition changes, and weekly as a minimum.		
14/8/19	1435	TP	Ensure rationale for decision made re; the use of bedrails is clearly documented.		
14/8/19	1435	TP	Consider psychological effects of bedrail usage on patient and where appropriate ensure the patient's consent to their use.		
14/8/19	1435	TP	Ensure risk of entrapment is minimised by careful positioning of patient prior to operating bedrails.		
			If detachable bedrails used, ensure the gap between the top end bedrail and head of bed is less than 6cm or more than 25cm.		
			If detachable bedrails used, ensure the gap between the bottom end of bedrail and foot of bed is more than 25cm.		
			Continually monitor risk of patient climbing over the top of bedrails and assess the use of bedrails as necessary.		
			Discuss with the patient, the need to share information with other nurses and health care workers re; the use of bedrails, and document within the nursing documentation whether the patient consents to display information at the bed space.		
			Provide Falls/Use of Bedrails information leaflet to patient. Where the patient is incapacitated, ensure that relative/carer is given a leaflet and information about the assessment for bedrails is provided.		
			Ensure all actions, including discussions with relative/ carer are documented.		
			Refer to the Safe Use of Bedrails in Adult In-Patient Settings Guideline for further guidance on the management of bedrails.		
			Re-assess the need for bedrail use at least weekly or as the patient's condition indicates and document on the risk assessment chart.		
			This care plan has been discussed and agreed with the patient as appropriate.		

Moving & Handling
Patient Risk Assessment

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

All Patients:

Sliding aids **must** be used bed to trolley/bed unless the patient transfers independently
A hoist **must** be used if assistance is required from the floor
A hoist **must** be used for bathing unless independently mobile
Hoists are for lifting patients and must not be used for transport between rooms

Special Alerts: Date:	14/8/17	16/8/18				
Overweight / Obese (BMI definition)	✓	NO				
Very tall (>185cm in height)	✓	NO				
Restricted use of limbs	✓	NO				
Poor standing ability	✓	NO				
Sedation or lethargy	✓	NO				
Irrational behaviour / confusion	✓	NO				
Unable to co-operate	✓	NO				
Acute pain	✓	NO				

Assessment of Risk:

Low Risk: Independently mobile / supervision only required. Aids required should be specified in care plan

Moderate Risk: Requires physical assistance from one or more handlers. Is able to stand or partially bear weight and has no more than one special alert.

High Risk: (a) Is unable to bear weight and requires assistance.
(b) 2 or more special alerts present and requires assistance.

Aids, equipment and a minimum of 2 handlers recommended to move a patient.

Specify Level of Risk

Date:	14/8/17	16/8/18				
LOW RISK	✓	✓				
MODERATE RISK						
HIGH RISK						
Assessor's Initials	JP	LD				

If a hoist or standing aid is required please specify:

Sling type:		Size:		Manufacturer:	

Additional Comments:

Risk Assessment

Risk Assessment

MOVING AND HANDLING CARE PLAN

Date:	23/8/18	16/5/18				
1. Moving in bed:						
a) Independent	a) ✓	✓				
b) Handlers and sliding sheets required to move in bed - specify number of handlers in grid	b)					
c) Specify any additional equipment required in grid	c)					
2. Sitting to Standing:						
a) Independent	a) ✓	✓				
b) Requires assistance from sit/stand to sit? Specify number of handlers in grid	b)					
c) Also requires aids. Specify equipment in grid	c)					
4. Transfers: (chair / wheelchair / commode / toilet / bed)						
a) Independent or with minimal supervision	a) ✓	✓				
b) Assistance required from handlers specify number of handlers in grid.	b)					
c) Equipment required - specify equipment in grid	c)					
4. Adjusting Clothing						
a) Independent or minimal supervision	a) ✓	✓				
b) Can use support/grab rails while assistance is given with clothing	b)					
c) Requires support from Handler(s) while another assists with clothing	c)					
d) Requires equipment, specify equipment in grid	d)					
5. Repositioning in chair / wheelchair:						
a) Independent or minimal supervision	a) ✓	✓				
b) Assistance from handler(s), specify number in grid	b)					
c) Specify other aids or equipment required in grid	c)					
6. Mobilising:	Documented in Mobility Care Plan					
Assessors initials						

If it is decided to stand, transfer or mobilise a patient requiring assistance of more than 2 handlers, without equipment, a detailed assessment outlining the decision making process must be documented in the mobility careplan.

Mobilising - Care Plan

Write or attach label

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

Patient Problem/Need
Patient has restricted mobility/mobility is deteriorating due to.....
Goal
To optimise ability to mobilise safely and maintain independence as much as possible

Date	Time	Initial	Planned Nursing Interventions	Discontinued Date/Time	Initial
			Refer to moving and handling risk assessment tool and plan care accordingly.		
			Mobilise/transfer with assistance of one/two handlers.		
			Mobilise/transfer with supervision.		
			Mobilising with appropriate handling equipment and/or aids, please state:-		
			• Walking stick one/two		
			• Tripod/quad		
			• Zimmer frame/rolator		
			• Wheel chair		
			• Hoist aid (specify equipment used)		
			• Other (please specify)		
			Refer to physiotherapist and action specialist requirements.		
			This care plan has been discussed and agreed with the patient and/or carer/relative as appropriate.		

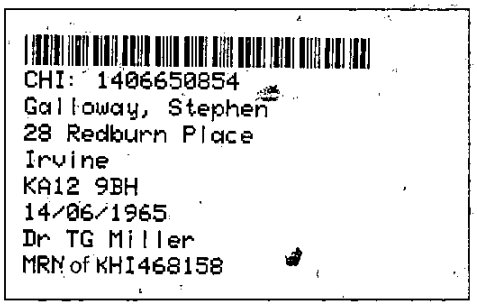
Risk Assessment

Risk Assessment

Referrals to Multidisciplinary Team During Admission

Date	Initials of staff making referral	Referrals	Contact Number/ Page	Date Reviewed	Initi
		Alcohol Liaison Team			
		Community Learning Disability Team			
		Community Mental Health Team			
		Community Mental Health Team Elderly			
		Community Nurse			
		Community Psychiatric Liaison Team			
		Community Psychiatric Liaison Team Elderly			
		Dental			
		Diabetic Team			
		Dietitian			
		Discharge Co-ordinator			
		~~Fresh Air-shire~~ Qvit Yavi Uky	Ext. 25838		Vctn
		Home Care Organiser			
		Intermediate Care and Enablement Services			
		Occupational Therapist			
		Palliative Care Team			
		Pain Team			
		Pharmacist			
		Physiotherapist			
		Podiatrist			
		Psychiatric Liaison Team			
		Speech and Language Therapist			
		Social Worker			
		Specialist Nurse			
		Tissue Viability			
		Other - please specify			

Care Plans and Monitoring Charts Evaluation


CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN of KHI468158

Code	Care Plan / Monitoring Chart	Code	Additional specific care plans / monitoring Charts
A	Admitted as an emergency	1	
B	Breathing	2	
C	Catheter	3	
D	Cleansing and dressing	4	
E	Elimination	5	
F	Falls	6	
G	Bedrails	7	
H	Mobilising	8	
J	Communication	9	
K	Pre - operative	10	
L	Post - operative	11	
M	Wound Management	12	
N	Pressure area care	13	
O	Oral Hygiene	14	
P	Pain Management	15	
R	MUST - Eating and Drinking	16	
S	Emotional Wellbeing/Anxiety	17	
T	MRSA	18	
V	MEWS	19	
W	Fluid Balance Chart	20	
X	PVC Chart	21	
Y	Investigations		
Z	Cognitive impairment		

Initial Presentation and Plan

Write or attach label

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: KHI468158

Ward CAU

Date & Time	Immediate presenting history (inc GP, ED or clinic)	Initi
13/6/18 14.20	Emergency admission with alcohol withdrawl NEWS 2 as charted. 10mgs of Diazepam given as prescribed. ~~Patient given diazp~~ Seen by SHO see plan below. Smoking disclaimer signed and coffee and water given to patient. Patient released lunch	TP

Ward Round Instructions / Goals of Care

Write or attach label
HCR No:
CHI No:
Surname:
Forename: Sex:
Address:
Date of Birth

Ward CAU

Date & Time	Ward Round Instructions	CLD	EDD	Initials
14/8/18	Reviewed by Dr Taylor.			
	1 - ETOH withdrawal.			
	- GMANS			
	- Pabrinex			
	- on reg diazepam.			
	nct scanng			
	Plan - ↓ diazepam to 15mg			
	QDS to cont detox			
	- Bloods mane.			PC

Ward Round Instructions

Ward Round Instructions

Ward _____

Date & Time	Ward Round Instructions	CLD	EDD	Initi

Write or attach label

HCR No:.....

CHI No:.....

Surname:.....

Forename:..... Sex:.....

Address:.....

.....

Date of Birth.....

Ward _____

Date & Time	Ward Round Instructions	CLD	EDD	Initials

Ward Round Instructions

Ward _____

Date & Time	Ward Round Instructions	CLD	EDD	Initi

CHI: 1406650854
HC Galloway, Stephen
CH 28 Redburn Place
Sur Irvine
For KA12 9BH
Adc 14/06/1965
Dr TG Miller
MRN: XHI468158
Date of Birth:

Ward CAU

Date & Time	Care plan Code	Nursing Evaluation	Initials
13/8/18	S	Settled this evening.	
		Has been outside 2 x per	
		Smoking Discharge.	
	V	NEWS (2) Sats 95% (A)	
		HR 94	
		Not requiring Gmans	
		@ present, continue to monitor.	
		No complaints raised.	SH.
14/8/18 0715.	S	Slept well overnight	
		Remains settled	
	V	NEWS 0 this morning.	
		Uncomplaining	SH.
14/8/18 1015	V	News ~~to~~ 0	
	D	Independently showered.	
	R	Managing diet & fluids	
	X	cannula patent. IV pabrinex given as charted.	
	S	Diazepam administered routinely as charted - no issues of withdrawal. Frequently	
1030	A	Pt to transfer to ward 3B, verbal handover given via telephone.	PE
	(A)	patient admitted to 5B.	
	S	Settled - not scoring on Gmans. Routine Diazepam given	
	X	IV pabrinex continues.	
	V	NEWS with satisfactory parameters.	
	R	Managing diet and fluids	
	H	Independently mobile	L

Nursing Care Evaluation

Ward 5B

Date & Time	Care plan Code	Nursing Evaluation	Initial
15/8/18	V	News as charted	
02.40	H	PT Independantly mobile around the ward	
		Out for cigarettes	
	E	Continent via the toilet	
	X	IV Pabinex administered	
		Diazepam 15mg given as prescribed	
	N	Skin bundle maintained	
	S	Settled and slept	
15/8/18	V	Obs stable	C
	P	No complaints of pain	
	S	Settled today, not scoring on GMAWS	
	N	SSI(N refused, Stoles intact	
	D	ADL personal care needs met	
	R	Good oral intake today	
	E	Continent to toilet	
	X	IV Pabinex cont as pr	EP
16/8/18	E	CONTINENT VIA TOILET OVERNIGHT	LD
04 10	H	INDEPENDENTLY MOBILE WITHIN WARD	
		AND OUTSIDE FOR CIGARETTES	L
	N	REPOSITIONING INDEPENDENTLY IN BED	LD
	P	APPEARS COMFORTABLE AND PAIN FREE	LD
	V	VITAL SIGNS STABLE	LD
	S	APPEARS TO HAVE SLEPT FOR FAIR	
		SPELLS. NO SIGNS OF ALCOHOL	
		WITHDRAWL, NOTED	LD
16/8/18	E	Continent via bottle @ bedside	
11.10	FIG	Adequate safety measures insitu	
	N	Skin bundle continues as charted	
	P	No complaints of pain offered	
	R	Managing normal diet/fluids	
	V	NEWS 2, BP 94/46 mmHg	
	X	Cannula removed	
	J	Rev by Dr Allen for discharge	

Write or attach label

HCR No:.....
CHI No:.....
Surname:.....
Forename:..... Sex:.....
Address:.....
.....
Date of Birth.....

Ward 5B

Nursing Care Evaluation

Date & Time	Care plan Code	Nursing Evaluation	Initials
		home. Await IDL ☐ ~~has~~ requires error	
cont.		transport ☐ ——————	DA
14.10		Collected by discharge lounge	DA

Multi-professional Communication Sheet

Write or attach label
HCR No:
CHI No:
Surname:
Forename: Sex:
Address:
Date of Birth

Ward _____

Date & Time	Communication and significant information discussed with multi professional team	Initials
14/8/18 @ 10:15am	Patient not automatically referred to service, spoke with S/N would not like referral to Quit Your Way. If patient changes their mind please refer for assessment.	MCM

Multiprofessional Communication Sheet

5B Nursing Handover

527

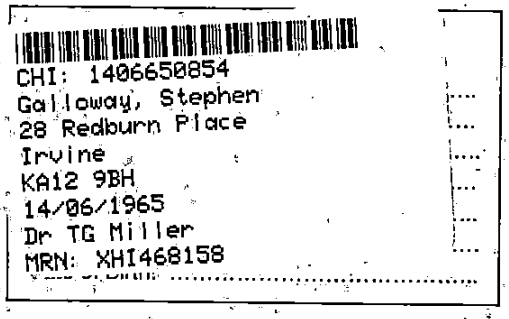
Name **Age**	Galloway. 53
NOK details	Partner
Social Situation	Lives Alone No services Smoker
PMH **Allergies**	Alcohol XS Prev DTs Childhood Asthma.
Assessment & Recommendation	Alcohol Withdrawal NO NF Reg Diazepam. Pabrinex CIWA WS Monitor Bowels ? ALN referral ☐

NHS
Ayrshire
& Arran

SMOKE FREE GROUNDS POLICY

DISCLAIMER GUIDANCE

Please note as part of the nursing admission documentation all those who smoke should be referred to the Fresh Air-shire team (by placing a patient sticker onto a referral card and then into the black box) so that they can provide information about the smoke free grounds policy and help the patient to manage their smoking while in hospital


CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

Smoke Free Grounds Policy

Patient Disclaimer

Hospital:	XH
Ward/Station/Dept:	CAV Orange
Patient Name:	STEPHEN GALLOWAY

I STEPHEN GALLOWAY (print name) have been provided with information regarding the management of smoking in hospital in compliance with the NHS Ayrshire & Arran Smoke Free Grounds Policy and I understand that I am not permitted to smoke anywhere on NHS A&A grounds.

I have read and understood this information. I have been advised against leaving the ward to smoke. I understand that there are risks associated with leaving the ward/department. In particular I understand that my decision will affect the medical attention I receive and that NHS Ayrshire & Arran cannot provide medical care and attention to me whilst I am absent from the ward/department. I therefore accept that the staff cannot be responsible for my care whilst I am absent from the ward and hospital grounds.

Patient Signature:		Witness Signature:	
Date:	13/8/18	Date:	13/8/18
Time:	1420	Time:	1420

PLEASE FILE THIS FORM IN NURSING NOTES ENSURING CIRCUMSTANCES ARE FULLY DOCUMENTED

CAU Pre / Initial Assessment

Date 24/8/16 Time 1345

Call Taken by PMNO

Patient Name/CHI 1406650854

Referral Source: GP/ED (delete as required) 12:12

Write or attach label

HR
CH CHI: 1406650854
Galloway, Stephen
Sur 28 Redburn Place
Irvine
For KA12 9BH
Adc 14/06/1965
Dr A Sharma
MRN: XHI468158
Date of Birth:

Mode of GP letter: GP mail box ☐ Patient ☐ Fax ☐

History from Referral Source Age ____

? Alk xS

(L) Sided parasthesia
Chest pain (L) side ↑BP

Observations from GP: BP 190/90 HR ____ T____ RR____ SpO2____ **MEWS**____ **Red Flag**____

Is Stroke suspected? (Apply Rosier Scale and See Stroke Guideline)

McKillop score (Deliberate Self Harm/Psychiatric isses) – Low/Medium/High Risk (Del as app). (See Guidelines overpage)

Likely outcome based on referral history and professional judgement:

Acute Clinic ☐ Ambulatory Care ☐ Rapid Assessment ☐ In-Patient ☐ Monitored Bed ☐

On PMS pre-admission ☐ On eWhiteboard ☐ Notes requested ☐

Arrival / Initial Assessment

Date ____ Time ____ Referral Letter ☐

MEWS Score ☐ **Red Flag** ☐ **Frailty Score** ☐ 4 AT(age >65) ☐

Is deliberate self harm suspected or is mental ill health evident? ☐
Apply Mental Health Risk Assessment.

Apply streaming tool and indicate planned location:

Acute Clinic ☐ Ambulatory Care ☐ Rapid Assessment ☐ In-Patient ☐ Monitored Bed ☐

Consent to display information ☐ Highlight on e-WB ☐

Presenting Complaint

Elevated MEWS or Red Flag - Initiate immediate review ☐ (Page 2nd on – pg 3513)

Initial Investigations

	Required	Requested	Sign	Reviewed		Required	Requested	Sign	Reviewed
U&Es					LFT's				
FBC					Trop T				
Glucose					TFT's				
Coag.screen					Others				
BMs					ECG				
Urine					CXR				

Brief clinical summary and plan (If patient reviewed in initial assessment area)

SBAR TEMPLATE FOR IMMEDIATE REVIEW

Situation – Identify yourself, the unit you're calling from, the patients name and describe your concern.

Background - State reason for admission, relevant PMH, relevant diagnostic and laboratory results.

Assessment - State your concern including vital signs and MEWS score and any Red Flags.

Recommendation - State you require urgent review, clarify timescale and determine immediate action to be taken.

ROSIER SCORE

Has there been a loss of consciousness or syncope?			Y(-1)	N (0)
Has there been seizure activity?			Y(-1)	N (0)
Is there NEW ACUTE onset (or awakening from sleep)?	**Right**	**Left**		
Asymmetric facial weakness			Y (+1)	N (0)
Asymmetric arm weakness			Y (+1)	N (0)
Asymmetric leg weakness			Y (+1)	N (0)
Visual field defect			Y (+1)	N (0)
Speech disturbance			Y (+1)	N (0)
Total Score (-2 to + 5)				

Provisional diagnosis:- Stroke ☐ TIA ☐ Non-stroke ☐ (specify)

RED FLAGS

Ongoing chest pain with ECG changes
New tachyarrythmia
New respiratory distress
Decreased GCS or seizures
Uncontrolled chest pain
SIRS+ve/Sepsis
Delirium

SIRS (2 or more criteria = SIRS +ve)

Temp < 36 or > 38 C
HR > 90bpm
RR > 20bpm
WCC < 4 or >12

Frailty Index

Functional impairment (new or existing) that impacts on independence in daily living

Assistance required for practical tasks in daily living (new or existing)- Personal care and meals provided by either private carers or relatives ☐

Mobility impairment that impacts on function (new or existing) including a fall within the last 3 months ☐

Delirium (4AT score ≥ 4) ☐

Dementia ☐

Resident in care home ☐

Total Score **If FI ≥ 2, write score on eWB**

Mental Health Risk Assessment (Respond Yes or No to each question)	1	2	3
Is the patient violent, aggressive or threatening?	Yes		No
Is the patient obviously distressed, markedly anxious or highly aroused?		Yes	No
Is the patient behaving inappropriately to the situation?		Yes	No
Is the patient quiet and withdrawn?		Yes	No
Do you think the patient presents a risk to you/ oneself or others?	Yes		No
Do you think the patient is likely to abscond prior to assessment?	Yes		No
Do you think the patient is experiencing delusions or hallucinations?	Yes		No
Do you think the patient feels influenced or controlled by external forces?	Yes		No
Are you aware of a history of violence or self harm?		Yes	No
Are you aware of a history of mental health problems or psychiatric illness?		Yes	No

All responses in column 1 (High Risk)- Move the patient to the clinical area immediately (accompanied if appropriate) and assess as soon as possible.

All response in column 3 (Low Risk)- The patient can wait for assessment (accompanied if possible), ideally in a place other than the waiting room. All other patients (Moderate Risk) can wait for assessment, ideally in a place other that the waiting room, but assess as soon as possible.

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NHS Ayrshire & Arran

ol Withdrawal Scale (GMAWS) **Treatment Option: GMAWS only** ☑ **GMAWS & Fixed Dose** ☑

Date	14/6/18		14/6/18	14/6/18	15/6/18	15/6	0/18	16/18	16/6/18	14/6	14/6	14/6					
Time	14:15	1300	2000	2245	0005	0240	0445	0625	0810	1130	1330	1630					
Tremor 0. No tremor 1.On movement 2. At Rest	2	1	0	0		0	0	0	0	0	0	0					
Sweating 0. No sweat visible 1. Moist 2. Drenching sweats	0	0	0	0		0	0	0	0	0	0	0					
Hallucination 0. Not present 1. Dissuadable 2. Not dissuadable	0	0	0	0		0	0	0	0	0	0	0					
Orientation 0. Orientated 1. Vague, detached 2. Disorientated, no contact	0	0	0	0		0	0	0	0	0	0	0					
Agitation 0. Calm 1. Anxious 2. Panicky	0	0	0	0		0	0	0	0	0	0	0					
Score	2	1	0	0	D/C SAC.				20mg Valium PO	0	0	0					
Treatment	10mg	Valium 10mg			Given 20mg Chlord												
Staff Signature																	

Score: (Do not use scoring tool if patient intoxicated, must be at least 8 hours since last drink.)

0 : Repeat Score in 2 hours (Discontinue after scoring on 4 consecutive occasions, except if less than 48hrs after last drink)

1 – 3 : Give 10mg Diazepam: Repeat Score in 2 hours

4 – 8 : Give 20mg Diazepam : Repeat Score in 1 hour

9 - 10 : Give 20mg Diazepam : Repeat Score in 1 hour, and discuss with medical staff regarding management of severe withdrawal as per guideline (see page 3)

PATIENTS MAY REQUIRE TO BE WOKEN FOR CONTINUING ASSESSMENT
CO-EXISTING ILLNESS MAY AFFECT SCORE: SEEK MEDICAL ADVICE IF IN DOUBT
FIXED DOSING & SYMPTOM TRIGGERED DOSING MUST BE NO LESS THAN 1 HOUR APART

All patients should have regular observations documented. Patients receiving high doses of Diazepam should be assessed regularly for over sedation.
Regular MEWS – Frequency 1-4hrs. (GCS, Respiration rate. Oxygen saturation, Pulse, Blood Pressure)

Paper 17

AYRSHIRE ASSESSMENT AND MANAGEMENT OF ALCOHOL WITHDRAWAL SYNDROME

NHS Ayrshire & Arran

CHI: 1406650854
Galloway, Stephen
28 Redburn Place
Irvine
KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

ALCOHOL HISTORY

Estimated Weekly Alcohol Units: (Daily Units x Number of Days per Week) > 200

Excessive weekly consumption (♂ >21 units/week; ♀>14 units/week)

Estimated day/time of last drink

(if > 5 days, re-consider alcohol withdrawal status)

Presents with (or previous history of) Alcohol Related Seizures Yes ☐ No ☐

Presents with (or previous history of) Severe Alcohol Withdrawal Yes ☐ No ☐

Number of Units = ABV (%) x Volume (litres)

e.g. A bottle of wine (750mls) which is 12% ABV = 12 x 0.75 = 9 Units
A glass of wine (200mls) which is 12% ABV = 12 x 0.2 = 2.4 Units

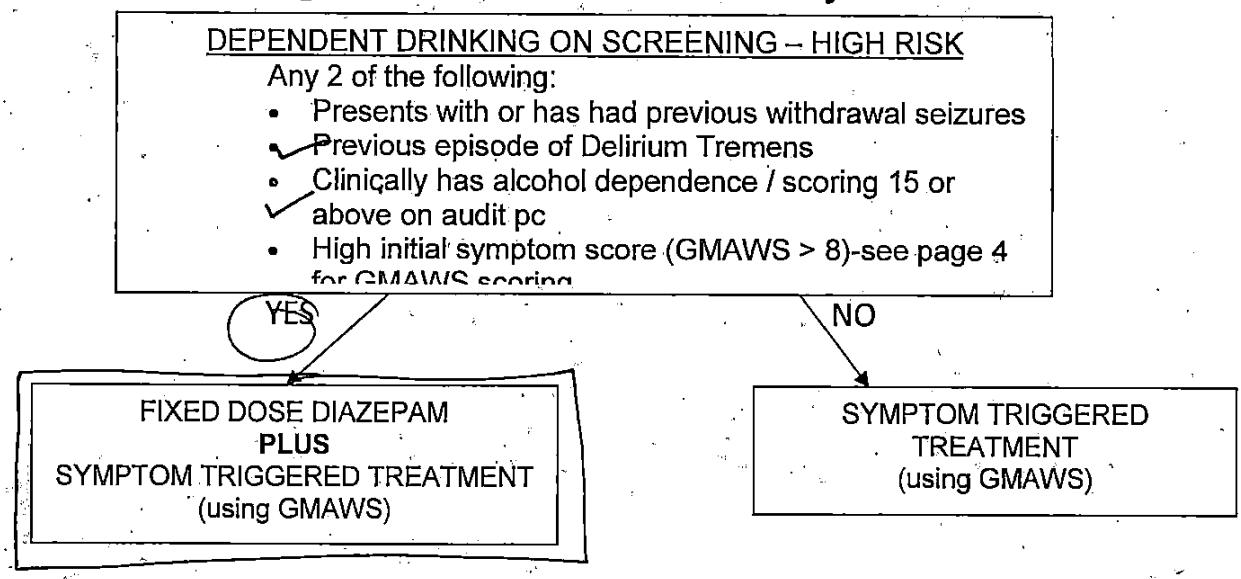
AUDIT PC

ALCOHOL SCREENING	SCORE					
	0	1	2	3	4	Total
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times a week	4 or more times a week	4
2. How many **units of alcohol** do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 or 8	10 or more	4
How often during the last year have you found that you were not able to stop drinking once you had started	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	4
4. How often during the last year have you failed to do what was normally expected of you because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	4
5. Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes but not in the past year		Yes during the past year	4
TOTAL SCORE:						20

0-5: Responsible drinking pattern **6-10: Hazardous drinking pattern** **11-14: Harmful drinking pattern**
15-20: Dependent drinking pattern

NHS Ayrshire & Arran

Management of Alcohol Withdrawal Syndrome



BASELINE TREATMENT REGIME

Fixed Dose oral Diazepam: (for patients unable to tolerate diazepam via the oral route, see below).

Initial 24 hours: **20mg Diazepam 6 hourly**

If no additional symptom triggered treatment, then REDUCE as follows:

15mg Diazepam 6 hourly for 24 hours
10mg Diazepam 6 hourly for 24 hours
5mg Diazepam 6 hourly for 24 hours
5mg Diazepam 12 hourly for 24 hours

Diazepam prescription to be reviewed if patient excessively drowsy.
Consider requesting senior medical review if greater than or equal to 120mg Diazepam is administered in 24 hours.

ELDERLY PATIENT GROUP (>65 years)

In general half the dose of benzodiazepines is usually recommended (the need for this is dependent on overall fitness, co-morbidity and degree of frailty). To minimise adverse effects associated with benzodiazepines (e.g. over sedation, confusion and ataxia) in the elderly it is important to bear in mind the start low and go-slow rule (start with lower doses, monitor frequently and increase if necessary as symptoms suggest).

EXCEPTIONAL PATIENT GROUPS:

- Head injury (refer to Clinical Decisions Unit Head Injury Pathway)
- Patients with evidence of liver disease: especially jaundice, encephalopathy
- Patients with other significant co-morbidity (i.e. COPD, pneumonia, cerebrovascular disease, reduced GCS)

Consider the use of oral Lorazepam in these exceptional patient groups in a symptom triggered fashion: 1-2 mg (to a maximum of 12mg in 24 hours before requesting senior medical review).

NHS
Ayrshire
& Arran

SEVERE WITHDRAWAL (aggressive/ uncontrollable/ dangerous behaviour)

- Intravenous Diazemuls® up to 40mg over first 30 minutes (up to 2mg/minute; flumazenil to be available) - see manufacturers Summary of Product Characteristics (SPC) or Medusa Injectable Medicines Guide for further information)
- Adjunctive therapy with Haloperidol if required- refer to ADTC 220 Rapid Tranquilisation Policy in Acute Hospital Wards link to ADTC 220

PATIENTS UNABLE TO TOLERATE ORAL MEDICATION

Patients unable to tolerate oral medication may receive intravenous therapy (Diazemuls® or lorazepam) as an alternative at 50% of the oral dose in the first instance, and response assessed.

MONITORING

- All patients should be closely observed for signs of over-sedation with regular observations
- Exceptional Patient Groups (see above), patients with Severe Withdrawal and patients requiring Intravenous or Intramuscular Sedation require close monitoring (MEWS) ideally with one-to-one nursing care.

PABRINEX ADMINISTRATION

- Please refer to ADTC 92 In-patient Guideline for treatment of Thiamine Deficiency in patients with Chronic Alcohol misuse using Pabrinex® Injection Link to ADTC 92
- All patients with chronic alcohol misuse plus evidence of malnutrition, in the DTs, with hypoglycaemia or signs / symptoms suggestive of Wernicke's Encephalopathy should be prescribed high dose parenteral Pabrinex® 2 pairs three times daily intravenously for 3-5 days or until clinical improvement ceases.

ROLE OF ALCOHOL LIAISON

- If Audit PC score indicates that the individual is drinking at harmful/hazardous levels referral to be made to Alcohol liaison.
- If the person is commenced on GMAWS refer to Alcohol Liaison (towards the end of their detox) for assessment and signposting onto community services.

DISCHARGE PLANNING

- Patients should not be routinely discharged whilst still on a significant dose of Diazepam as part of the detox.
- Chlordiazepoxide is the recommended benzodiazepine for community use. Seek advice if considering switching from Diazepam to Chlordiazepoxide at point of discharge.

APPROXIMATE ORAL BENZODIAZEPINE EQUIVALENCE

10mg Diazepam = 1mg Lorazepam = 30mg Chlordiazepoxide

supervision appropriate) if requirement for supervision changes please document on reverse in the evaluation section.

| | | |

CARE & COMFORT ROUND incorporating Falls and SSKIN bundles

NHS Ayrshire & Arran

Documentation codes

✓ - When care / action is given / completed **Re** – refused **A** - asleep **V** - variance – record on evaluation sheet on page 2
N/A – not applicable

It is not necessary to write in every box every time a care and comfort round is undertaken, only complete as required using the codes above

1. CARE & COMFORT ROUND

Frequency of rounding: 1hrly 2hrly 4hrly 6hrly (please circle, if frequency changes please document change in date row, above relevant column and in evaluation)

Date	13/8	13/8	13/8	13/8	14/8	14/8	14/8	14/8	14/8	14/8	14/8	14/8	14/8	14/8	14/8	14/8	15/8	15/8	15/8	15/8	15/8	15/8	15/8	16/8
Time – using 24-hour clock (record actual time completed)	1500	1635	1825	2200	0000	0300	0500	0800	1000	1130	1355	1530	1605	1900	2100	0110	0330	0830	1145	1405	1620	1840	2100	0300
Orientate to time & place as appropriate and encourage opportunity to express needs	✓	✓	✓	✓	A	A	✓	A	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Assess pain & ensure patient is comfortable (If Pain present - Commence pain chart and action)	✓	✓	✓	✓			✓		✓	✓		✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Encourage/support oral diet & fluids where appropriate	✓	✓	✓	✓			✓		✓	✓		✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Offer assistance to visit toilet/any other continence needs	✓	✓	✓				✓					✓	✓					✓	✓	✓	✓			
Assist with personal hygiene as required: **BB**-bed bath **IB**-immersion bath **BW**-basin wash **SH**-shower	N/A								Ind															
Offer assistance with oral care	N/A																							
Provide assurance that you will return in a timescale	✓	✓	✓	✓			✓		✓	✓		✓	✓	✓	✓	✓	✓	✓	A	A	✓	✓	✓	✓
Initials	TP	AB	AB						PC	HO		HO	HO					MC	MC	MC	MC	MC	PW	PW
Designation	SN	NA	NA						SIP	NA		NA	NA					NA	NA	NA	NA	NA	NA	NA

ONLY to be completed if the patient triggers on the falls for all bundle (see in patient profile) and all patients in older peoples' wards. Please record N/A if any aspects of the falls bundle is not relevant to the patient (i.e. patient does not require walking aid, footwear or glasses or unable to use their call bell)
ALL aspects of the bundle must be completed at every bundle completion

2. VULNREABLE FALLS BUNDLE

Frequency of bundle completion: 1hrly 2hrly 4hrly 6hrly 8hrly 12hrly (please circle, if frequency changes please document change in date row, above relevant column and in evaluation)

Date	13/8	13/8	13/8	13/8	14/8	14/8	14/8	14/8	14/8	14/8	14/8	14/8	14/8	14/8			15/8	15/8	15/8	15/8	16/8			
Time – using 24-hour clock (record actual time completed)	1503	1635	1825	2200	0000	0300	0500	0800	1000	1130	1355	1530	1605	1900	2100	0110	0330	0830	1405	1620	2400	0700		
Environment is clear of clutter & well lit	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Call buzzer in reach & working	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Appropriate footwear available & in use	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
If glasses & hearing aid worn, they are available & in use	✓	✓	✓	✓	✓	✓	✓	✓				✓		✓	✓	✓	✓	✓	✓	✓	✓	✓		
Provision of walking aid as required & is within reach Please circle: Walking stick / Zimmer frame / Other.....	N/A																							
Chair & bed consistently at best height for individual, to enable safe transfers	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
DAILY assessment of the requirement for higher level	Higher level supervision required Yes / No - If Yes - Cohort Nursing or 1-1 Nursing (please circle as																							

| | | |

CARE & COMFORT ROUND incorporating Falls and Skin bundles

NHS Ayrshire & Arran

Documentation codes

✓ - When care / action is given / completed **Re** – refused **A** - asleep **V** - variance – record on evaluation sheet on page 2
N/A – not applicable

It is not necessary to write in every box every time a care and comfort round is undertaken, only complete as required using the codes above

1. CARE & COMFORT ROUND

Frequency of rounding: 1hrly **2hrly** 4hrly 6hrly (please circle, if frequency changes please document change in date row, above relevant column and in evaluation)

Date	18/8	18/8	18/8																						
Time – using 24-hour clock (record actual time completed)	08 00	11 15	13 30																						
Orientate to time & place as appropriate and encourage opportunity to express needs	✓	✓	✓																						
Assess pain & ensure patient is comfortable (If Pain present - Commence pain chart and action)	✓	✓	✓																						
Encourage/support oral diet & fluids where appropriate	✓	✓	✓																						
Offer assistance to visit toilet/any other continence needs																									
Assist with personal hygiene as required: **BB**-bed bath **IB**-immersion bath **BW**-basin wash **SH**-shower	SH																								
Offer assistance with oral care																									
Provide assurance that you will return in a timescale	✓	✓	✓																						
Initials	TC	TC	TC																						
Designation	NA	NA	NA																						

ONLY to be completed if the patient triggers on the falls for all bundle (see in patient profile) and all patients in older peoples' wards Please record N/A if any aspects of the falls bundle is not relevant to the patient (i.e. patient does not require walking aid, footwear or glasses or unable to use their call bell)
ALL aspects of the bundle must be completed at every bundle completion

2. VULNREABLE FALLS BUNDLE

Frequency of bundle completion: 1hrly 2hrly 4hrly **6hrly** 8hrly 12hrly (please circle, if frequency changes please document change in date row, above relevant column and in evaluation)

Date	18/8	18/8	18/8																						
Time – using 24-hour clock (record actual time completed)	08 00	11 15	13 30																						
Environment is clear of clutter & well lit	✓	✓	✓																						
Call buzzer in reach & working	✓	✓	✓																						
Appropriate footwear available & in use	✓	✓	✓																						
If glasses & hearing aid worn, they are available & in use	✓	✓	✓																						
Provision of walking aid as required & is within reach Please circle: Walking stick / Zimmer frame / Other.....																									
Chair & bed consistently at best height for individual, to enable safe transfers																									
DAILY assessment of the requirement for higher level	Higher level supervision required Yes / No - If Yes - Cohort Nursing or 1-1 Nursing (please circle as																								

NHS Ayrshire & Arran

Adult Peripheral Vascular Cannula Insertion and Maintenance Bundle

INSERTION BUNDLE

Date Inserted	Time Inserted	Staff Group/ Ward Inserted	Insertion Site	Gauge/Colour	Signature
13-8-18	1125	CAU	(L) ARM	PINK	

Clinically Indicated due to:

- IV Fluids / IV Drugs ☒
- Urgent Access ☐
- Interventional Procedures ☐

Clean field used	Hand hygiene	Skin Asepsis	Dressing date & time	Non touch technique used
☒	☒	☒	☒	☒

CHI: 1406650854
Galloway, Stephen
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KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

MAINTENANCE BUNDLE

Hand hygiene must be performed before & after all procedures. Prior to access, the hub must be scrubbed with 2% CHG & 70% IPA (Green Clinell Wipe)

PVC	1 Has the PVC been used in past 24hrs	2 The cannula dressing is intact	3 The cannula has been inserted <72hrs	4 Absence of inflammation and/ or extravasation	Phlebitis Score (see below)	Tick if PVC removed	Reason for removal (See codes below)	Sign
Day 1 13/8/18	Yes ☒ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐		Yes ☐ No ☑		
Day 2 .../.../....	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐		
Day 3 .../.../....	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐		
Cannulas should be removed after 72 hours and should only be left insitu in exceptional circumstances. Close observation essential - document reason								
Day 4 .../.../....	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐		
Day 5 .../.../....	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐		

Date	Comment	Initials
8/8/18	Flushed as per Policy	

Phlebitis Score		
IV Site Healthy	0	Observe
Pain/Redness/Swelling/Tracking/Pyrexia (not all symptoms require to be present)	1	Remove/Resite/Review/Consider treatment

Reason for Removal	
Signs of Infection	A
Tissued	B
IVs discontinued	C
Dislodged	D
Patient Removed	E
In more than 72 hours	F

NHS Ayrshire & Arran

Adult Peripheral Vascular Cannula Insertion and Maintenance Bundle

INSERTION BUNDLE

Date Inserted	Time Inserted	Staff Group/ Ward Inserted	Insertion Site	Gauge/Colour	Signature

Clinically Indicated due to:	IV Fluids / IV Drugs ☐ Urgent Access ☐ Interventional Procedures ☐

Clean field used ☐	Hand hygiene ☐	Skin Asepsis ☐	Dressing date & time ☐	Non touch technique used ☐

Write or attach label

HCR No: .....
CHI No: .....
Surname: .....
Forename: ..... Sex: .....
Address: .....
.....
Date of Birth: .....

MAINTENANCE BUNDLE

Hand hygiene must be performed before & after all procedures. Prior to access, the hub must be scrubbed with 2% CHG & 70% IPA (Green Clinell Wipe)

PVC	1 Has the PVC been used in past 24hrs	2 The cannula dressing is intact	3 The cannula has been inserted <72hrs	4 Absence of inflammation and/ or extravasation	Phlebitis Score (see below)	Tick if PVC removed	Reason for removal (See codes below)	Sign
Day 1 .../.../....	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐		
Day 2 .../.../....	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐		
Day 3 .../.../....	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐		
Cannulas should be removed after 72 hours and should only be left insitu in exceptional circumstances. Close observation essential - document reason								
Day 4 .../.../....	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐		
Day 5 .../.../....	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐		

Date	Comment	Initials

Phlebitis Score		
IV Site Healthy	0	Observe
Pain/Redness/Swelling/Tracking/Pyrexia (not all symptoms require to be present)	1	Remove/Resite/Review/Consider treatment
Reason for Removal		
Signs of Infection	A	
Tissued	B	
IVs discontinued	C	
Dislodged	D	
Patient Removed	E	
In more than 72 hours	F	

NEWS
National Early Warning Score

	Date	Ward
Admitted		
Transferred		
Transferred		

N: CHI: 1406650854
Galloway, Stephen
D 28 Redburn Place
Irvine
C KA12 9BH
14/06/1965
Dr TG Miller
MRN: XHI468158

NHS Ayrshire & Arran

Special Instructions - to be completed by Medical Team

A total NEWS score of _____ due to _____ or individual parameter range of _____
is acceptable for this patient because _____

_____

Please escalate if _____

_____

Print _____ Sign _____ Designation _____
Date _____ Time _____ *(only valid if signed and dated)*

A total NEWS score of _____ due to _____ or individual parameter range of _____
is acceptable for this patient because _____

_____

Please escalate if _____

_____

Print _____ Sign _____ Designation _____
Date _____ Time _____ *(only valid if signed and dated)*

See NEWS Actions Reference Tool for local escalation policy

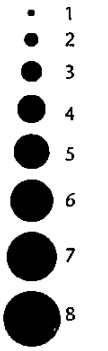
News score	Frequency of monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations
Aggregate 1-4	Minimum 4 hourly	• Inform trained nurse • Trained Nurse assessment - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate
Aggregate 5 or more *or* any single red score	Increase frequency to a minimum of 1 hourly	• Trained Nurse assessment • Inform medical team caring for the patient and dual response • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately • Inform medical team caring for the patient - this should be at least senior medical staff level. If unable to attend promptly, escalate to consultant or Emergency Response Team. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. • Consider referral to high dependency or ITU.

Neurological Observations

Date																												
Time																												
COMA SCALE	E	Spontaneously	4																									Eyes closed by swelling = C
	Eyes open	To speech	3																									
		To pain	2																									
		none	1																									
	V	Oriented	5																									Endotracheal tube or tracheostomy = Y
	Best verbal response	Confused	4																									
		Inappropriate words	3																									
		Incomprehensible sounds	2																									
		None	1																									
	M	Obeys	6																									Usually record the best arm response
	Best motor response	Localises	5																									
		Flexion - withdrawal	4																									
		Flexion - abnormal	3																									
		Extension to pain	2																									
		None	1																									
	TOTAL SCORE																											
PUPILS	R	Size																										+ reacts - no reaction c eyes closed
		Reaction																										
	L	Size																										
		Reaction																										
LIMB MOVEMENT	ARMS	Normal power																										Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness																										
		Severe weakness																										
		Spastic flexion																										
		Extension																										
		No response																										
	LEGS	Normal power																										
		Mild weakness																										
		Severe weakness																										
		Spastic flexion																										
		Extension																										
		No response																										

Glasgow Coma Scale

Pupil size (mm)



Pain Score

Ask the patient to rate his/her pain by choosing a number between 0 and 10.
Use the diagram below to assist the patient. If the patient's pain is chronic, use the generic tool. If the patient is unable to communicate, use the observational tool.

0	1	2	3	4	5	6	7	8	9	10	A
No Pain	Mild Pain			Moderate Pain			Severe Pain				Asleep

Nausea and Vomiting
0 - None
1 - Mild (Not distressing - no retching/ vomiting)
2 - Moderate (Troublesome - occasional retching/vomiting)
3 - Severe (Distressing - frequent retching/ vomiting)

Physiological Parameter	NEWS - NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92 - 93	94-95	>96			
Any Supplementary Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

Our purpose

Working together to achieve the healthiest life possible for e[illegible]ran

NHS Ayrshire & Arran

XH-16-048324-1
DOB: 14/06/1965 Male
Name: GALLOWAY Stephen
28 REDBURN PLACE, IRVINE
KA12 9BH
CHI Number: 1406650854

PATIENT PROFILE

Please complete below when patient is admitted or transferred to your clinical area

	Admission		Transfer 1		Transfer 2		Transfer 3	
Hospital	Crosshouse							
Ward	CAU - orange							
Consultant	Manuel							
Date / Time	24/8/16	1625						
Relative Informed	Yes	(No)	Yes	No	Yes	No	Yes	No
ID Band in situ	Yes	No	Yes	No	Yes	No	Yes	No
Completed By - Signature	[illegible]Clelland							

The Patient Profile can be used for patients with ongoing regular treatment i.e. for a course of therapy or weekly blood transfusion, however if there is a gap of more than 6 weeks since last attendance repeat lifestyle assessment (p15).

This profile can also be used for readmission within 3 days.
Please remember to review earlier risk assessments.

Property handed over for safe keeping

PLACE VALUABLES STICKER HERE

Our values

Caring Safe Respectful

Clinical Team Signatures

All staff completing the documentation **must** complete this section

Attach label

XH-16-048324-1

H DOB: 14/06/1965

C

S GALLOWAY Stephen Male

F 28 REDBURN PLACE, IRVINE KA12 9BH

1406650854

Name (BLOCK CAPS)	Profession	Ward/ Page No	Signature	Initials
DONNA MCELHINNEY	SIN	CTU - Virgo	DMcElhinney	DMc

Abbreviations

This abbreviation list has been approved for use by NHS Ayrshire & Arran

ANP	Advanced Nurse Practitioner	ICES	Intermediate Care and Enablement Services
ABG	Arterial Blood Gas	ICU	Intensive Care Unit
BM	Blood Glucose Monitoring	IM	Intramuscular
BMI	Body Mass Index	INR	International Normalised Ratio
BO	Bowels Open	IV	Intravenous
BP	Blood Pressure	LFTs	Liver Function Tests
CABG	Coronary Artery Bypass Graft	L+S BP	Lying and Standing Blood Pressure
CAU	Combined Assessment Unit	MAR	Medication Administration Record
CCU	Coronary Care Unit	MEWS	Modified Early Warning Score
CDI	Clostridium Difficile Infection	MHC	Medical High Care
CDU	Clinical Decisions Unit	MI	Myocardial Infarction
CHI	Community Health Index	MRI	Magnetic Resonance Imaging
CKD	Chronic Kidney Disease	MRSA	Methicillin Resistant Staphylococcus Aureus
CLD	Criteria Led Discharge	MSSU	Mid Stream Specimen of Urine
CLDT	Community Learning Disability Team	MUST	Malnutrition Universal Screening Tool
COPD	Chronic Obstructive Pulmonary Disease	NAD	No Abnormalities Detected
CPR	Cardio Pulmonary Resuscitation	NBM	Nil By Mouth
CRP	C - Reactive Protein	NG	Nasogastric
CSU	Catheter Specimen of Urine	NOF	Neck of Femur
CSW	Clinical Support Worker	O2	Oxygen
CT	Computerised Tomography	OT	Occupational Therapist
CVC	Central Venous Catheter	PEG	Percutaneous Endoscopic Gastrostomy
DOB	Date of Birth	PICC	Peripherally Inserted Central Catheter
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation	PMH	Past Medical History
ECG	Electrocardiogram	PN	Parental Nutrition
ED	Emergency Department	PVC	Peripheral Vascular Catheter
EDD	Estimated Date of Discharge	SP02	Saturation of Peripheral Oxygen
ERCP	Endoscopic Retrograde Cholangiopancreatography	SBAR	Situation Background Assessment Recommendations
ERT	Emergency Response Team	SC	Subcutaneous
ESBL	Extended Spectrum Beta Lactamase	SLT	Speech and Language Therapy
ESR	Erythrocyte Sedementation Ratio	TFTs	Thyroid Function Tests
FBC	Full Blood Count	USS	Ultra Sound Scan
GP	General Practitioner	U&Es	Urea and Electrolytes
H@N	Hospital at Night	UTI	Urinary Tract Infection
HAI	Healthcare Associated Infection	WCC	White Cell Count
HDU	High Dependency Unit	WZF	Wheeled Zimmer Frame

Personal Details

Personal Details

Prefers to be known as: Stevie	Age: 51.
Receiving Consultant:	Allocated Consultant:
From where: Home.	Accompanied by: pt came by bus.
Emergency ☐ Elective ☐	Patients telephone number:
	Patients mobile number: 07468 337186

Write or attach label

H(
Cl XH-16-048324-1
Su DOB: 14/06/1965 Male
Fo GALLOWAY Stephen
Ad 28 REDBURN PLACE, IRVINE KA12 9BH
Da

GP Name: Dr Kingsmore
GP Address: Few Terrace Surgery Irvine

Reason for Admission	Next of Kin/First contact/Significant other
left sided chest pain. Pt reports tingling and numbness to left arm	Name: Miss. Fraser. Address: Relationship to patient: ex partner. Contact No(s) Home: Mobile: Aware of admission Yes ☐ No ☐ Contact overnight Yes ☐ No ☐ Consent to share information with significant other listed: Yes ☐ No ☐
Patients Account of Reason for Admission	**Second contact/significant other**
Since sunday left sided paraesthesia left sided chest pain. Tingling and numbness down left arm.	Name: Address: Relationship to patient: Contact No(s) Home: Mobile: Aware of admission Yes ☐ No ☐ Contact overnight Yes ☐ No ☐
Specific Alerts	**Specific Alerts**
Previous known MRSA Yes ☐ No ☑ Ensure risk assessment completed	Drug Allergies: no drug allergies.
Clostridium Difficile Yes ☐ No ☑	Other allergies (food, latex, etc)
ESBL Yes ☐ No ☑	
Other infectious conditions? Yes ☐ No ☑ Specify:	None known ☐

Observation on admission	+ ++ +++ ++++	+ ++ +++	+ ++ +++ ++++	+ ++ +++	-ve +ve
Urinalysis NAD ☐	Protein Trace	Blood Trace	Glucose Trace	Leucocytes Trace	Nitrates
MSSU collected?		Yes ☐	No ☐	Date.....	

Glucometer Reading: Yes ☐ No ☐ Result:.....	Date Last Menstrual Period (if appropriate)	Pregnancy Test (if appropriate) +ve ☐ -ve ☐

Pain Score	low						severe				
	0	1	2	3	4	5	6	7	8	9	10
For patients with cognitive impairment please refer to Abbey pain scale											

Personal Details

Previous medical, surgical and mental health history

Details	Date (if Known)	Details	Date (if Known)
erectile dysfunction.			
alcohol excess			
paras RTA 2015 (multiple head injuries but signed self out @ EUH).			
perious chest pain/arm numbness. ETT as OPA did not attend)			

Any important information regarding medications.....

Own medication retained on ward Yes ☐ No ☑

Have the medications been returned to relatives? Yes ☐ No ☑

Please complete below when patient is admitted or transferred to your clinical area

Verbal information given to patient and / or relatives:	Ward: CAU		Ward:		Ward:		Ward:	
	Yes	N/A	Yes	N/A	Yes	N/A	Yes	N/A
Call buzzer If patients unable to use buzzer ensure this is reflected in care planning	✓							
Toilets / Bathroom	✓							
Explained Protected Mealtimes								
Visiting times	✓							
Hand hygiene								
Valuables								
Smoking								
Patient Discharge Booklet given								
Other								

Patient's Property - Where possible send belongings home with family

You are asked to keep belongings/valuables to a minimum whilst in hospital. You are responsible for property belonging to you not handed over for safe custody. This includes cash, spectacles, hearing aids, dentures and other personal items and valuables. Valuables should be sent home at first opportunity or given to the nurse if this is not possible.

Valuables handed over for safe keeping will be sent to the cashier's office and a receipt will be issued. If patient lacks capacity please ensure relevant documentation is completed for belongings and valuables.

Signature of Patient / Significant Other: _____ Date 24/8/16

Property handed over for Safe Keeping: Yes ☐ No ☐ Sticker on front page: Yes ☐ No ☐

Date taken to Cashier:_____ Cash & Valuables Ref No:_____ Date Returned:_____

Personal Details

Personal Details

Cognitive assessment

	Circle		
	1st Assessment	Further Assessment	Further Assessment
		Date	Date
4AT Score in A/E - ☐			
Ask the patient the following questions: (4AT)			
1. ALERTNESS			
This includes patients who may be markedly drowsy (eg. Difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gently touch on shoulder. Ask the patient to state their name and address to assist rating			
Normal (fully alert), but not agitated, throughout assessment)	0	0	0
Mild sleepiness for <10 seconds after waking, then normal	0	0	0
Clearly abnormal	4	4	4
2. AMT4			
Age, date of birth, place (name of the hospital or building), current year.			
No mistakes	0	0	0
1 mistake	1	1	1
2 or more mistakes/untestable	2	2	2
3. ATTENTION			
Ask the patient "Please tell me the months of the year in backwards order, starting at December". To assist initial understanding one prompt of "what is the month before December?' is permitted.			
Months of the year backwards, Achieves 7 months or more correctly	0	0	0
Starts but scores <7 months / refuses to start	1	1	1
Untestable (cannot start because unwell, drowsy, inattentive)	2	2	2
4. ACUTE CHANGE OF FLUCTUATING COURSE			
Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. Paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs			
No	0	0	0
Yes	4	4	4
4 or above: possible delirium +/-cognitive impairment: refer to algorithm			
1-3: possible cognitive impairment			
0: delirium or cognitive impairment unlikely (but delirium still possible if [4] information incomplete)			
4AT SCORE			

If you have concerns regarding capacity, please refer to algorithm and dementia/delirium care plans.

If no 4AT carried out please document reason eg Patient unconscious.....

Nurse Initials: .....Date:.....

Informed Consent and Capacity

While undertaking the patient's clinical assessment, if you have any concerns regarding the patient's capacity and ability to make healthcare decisions refer to medical staff for **assessment and treatment plan** under the Adults With Incapacity (Scotland) Act 2000 and document your actions within the nursing notes. Refer to the Consent policy for further guidance.

Information about the patient can be obtained from relatives and carers including legal guardians (e.g. guardianship through the social work department)

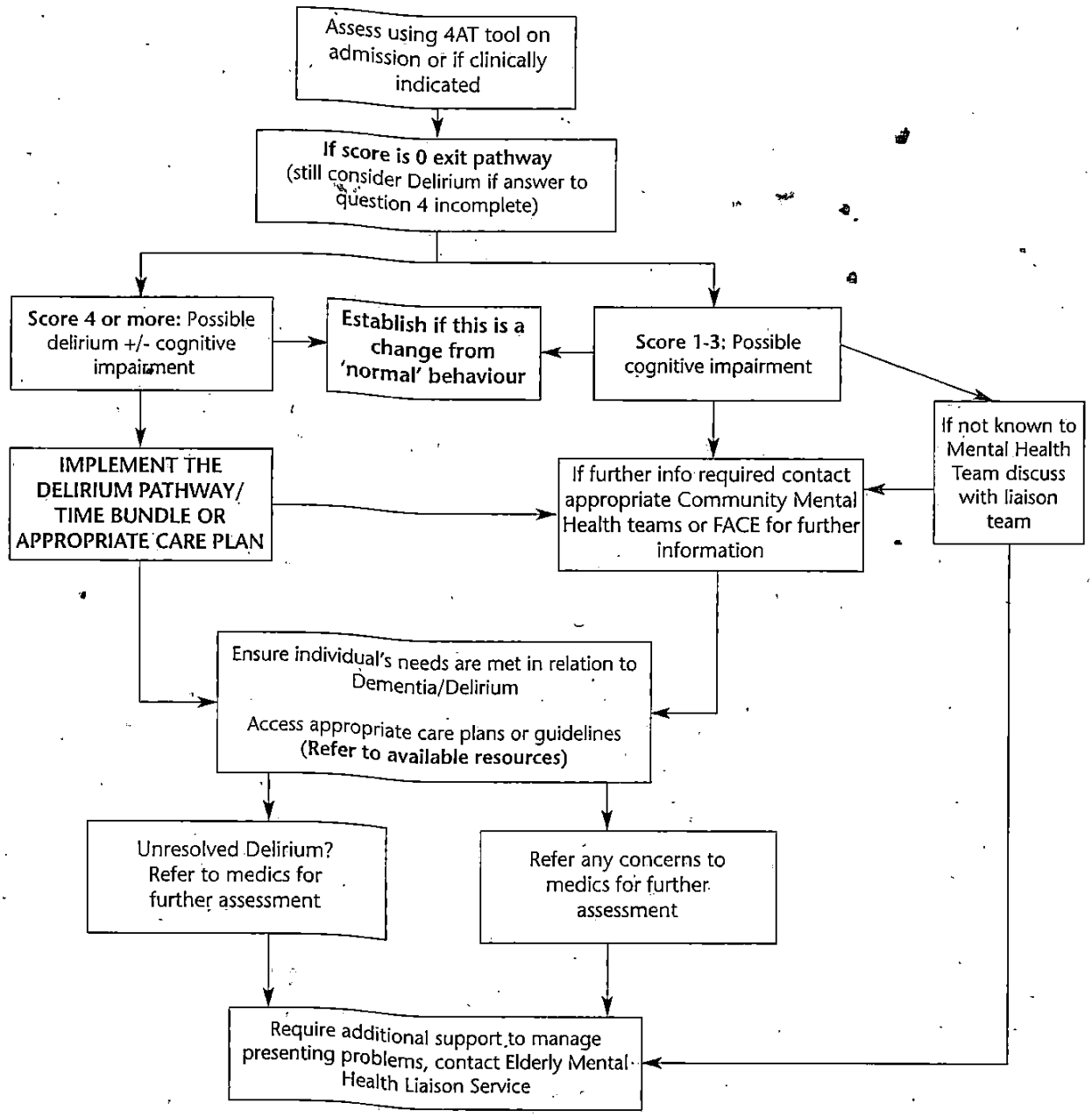
Relatives and carers cannot make decisions for patients except in certain circumstances where they hold Welfare Guardianship or Power of Attorney extending to health care decisions under the Adults With Incapacity (Scotland) Act 2000.

	Yes	No			Names
Advanced Statement	☐	☐			.....
Power of Attorney details	☐	☐	Financial ☐	Welfare ☐	.....
Guardianship details	☐	☐	Financial ☐	Welfare ☐	.....
"Getting to know me" in use	☐	☐			.....

If yes to any of the above obtain a copy of the relevant document.

If diagnosis of dementia is confirmed please ensure appropriate documentation / care plans are initiated

Nursing Assessment and Management of Cognitive Impairment



Useful Contact numbers

If patient has diagnosis of dementia and lives:
Nursing/Care Home: Contact **Elderly Mental Health Care Home Liaison Nurse** who will be able to provide background information regarding patient and support discharge arrangements.

Telephone no:.....

At home: Contact **Community Mental Health Team** as patient likely to be known to them>they may offer advice and/or background info.

Telephone no:.....

If patient does not have a diagnosis of dementia but further advice/support req'd whilst an in-patient, contact: **Elderly Mental Health Liaison service**

Telephone no:.....

If patient is known to any of the Mental Health Teams please inform when fit for home/discharge plans.

Useful Available Resources

Access Cognitive Impairment Guideleines if available or:
Getting to Know Me - hand held document used by patients
Dementia Care Plan - for pts with a diagnosis of dementia
Dementia and Behaviour Care Plan - for pts displaying behavioural and psychological symptoms of dementia (BPSD)
Delirium Care Plan - for pts displaying symptoms indicative of delirium
Behaviour that challenges guidance - found on back of Dementia and Behaviour Care Plan
Identification and Management of Delirium in the Elderly - can be found on back of Delirium Care Plan
Behavioural and Psychological Symptoms associated with Dementia - a guide to cause and management in behaviour that challenges in delivery of care of patients with dementia
Abbey Pain Scale - pain tool that should be used for pts with dementia and/or who cannot verbalise
Time Bundle - consider Time Bundle for patients with 4AT of 4 or more

All of the above resources can be accessed through Athena or in Dementia Resource Folder if available.

Personal Details

Personal Details

Adults at risk

Adults at risk are adults who:

a) are unable to safeguard their own well-being, property, rights or other interests
b) are at risk of harm, and
c) because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.

Adult Support and Protection (Scotland) Act (2007)

A vulnerable patient may be a person who:

- has a physical or sensory disability
- has a mental illness or dementia
- has a learning disability
- has current or history of substance misuse
- has social or emotional problems

A person's vulnerability will depend on their circumstances and environment, and each case must be considered individually. **Is this patient vulnerable** Yes ☑ No ☑

IF 'YES' COMPLETE VULNERABLE PATIENT ASSESSMENT FORM

Consent to display limited information

Patient consents to display of CHI number and limited personal information about care (e.g. bedrails, diet, mobility, "forget me not") on a chart at the bedside and whiteboard etc.

Consent given: Yes ☑ No ☐ By whom: Patient ☑ Relative/Carer ☐

If the patient has declined to consent to information being displayed at the bed space please provide information here .....

.....

Nurse Initials ..... Date 24/8/16

Useful Contacts:

To support your plan of care for this patient you might find it helpful to contact the relevant liaison service below:

Learning Disability Liaison Nurse Specialist:	01294 323560 (north) 01292 614910 (south) 01563 578574 (east)
Mental Health Liaison Nurses (Elderly Services)	01292 513007
Psychiatric Liaison Nurse (Adult general hospitals)	01563 826120
Advocacy Services	01294 608664 (north) 01292 264396 (south) 01563 574442 (east)
Hospital Social work team	Hospital site contacts through switchboard.

Additional relevant information (including details of the relevant liaison service contacted)

Person-centred care is where the patient is an equal partner with the health or care professional and where both parties work together to make an assessment, identify options for and the delivery of the most appropriate care. The care provided is holistic and the 'whole person' sits at the centre of the care package, which may be delivered by a range of health and social care professionals.

To promote person-centred care our focus is changing from asking 'What's the matter with you' to asking 'What matters to you'. We can do this by reliably covering the five 'Must do with me' elements of care with patients and/or their families and carers. This will help to ensure all of the interactions between people using our services and the staff delivering them are person-centred and are characterised by listening, dignity, compassion and respect.

5 Must do's. These can be answered by patient/family/carers.

What is important or matters to you?

What are the most important things for you that we can help you with/ do for you while you are here? e.g; *'that my wife/husband can be present when the consultant talks to me'; 'that I can choose my meal rather than someone else choosing it for me'; 'that my pet has been taken care of'; 'that my medication is given at the right time';*

finding out what's the matter.

Who matters to you?

Who are the most important people to you and how would you like them involved in your care? eg. family, friend, chaplain; minister, priest.

me and family

What information do you need?

eg when will the doctor see me'; 'visiting times'; 'meal times'; 'Can I smoke'; 'can I get out of the bed'; 'can I wear outdoor clothes in the ward'; 'what is the name of my nurse'; 'what can and can't I do'; 'how to contact relatives'; 'if mobiles can be used'; 'how to use Hospedia;'

Do you require any assistance to understand information e.g. Family / other Yes ☐ No ☐

Leaflets / written: Yes ☐ No ☐

Personalised Contact

As much as possible, try to be flexible about the timing of interventions to meet the patients personal needs. *Example questions of this could be, Would it be ok if we check on you every 1-2 hours to check you are ok or if you need anything?*

Nothing about you without you

Whilst you are in the ward we will involve you in any decisions regarding your care and discuss any referrals with you.

Nurse Initials ..... Date 24/8/16.

Personal Details

Personal Details

Home Circumstances

Home circumstances on admission

Do you have a carer: Yes ☐ No ☑
If yes: Family ☐ Private ☐
Do you live:-
Alone Yes ☑
With dependent partner ☐
With independent partner / family ☐
Does carer require additional support (Consider referral to social work) ☐
Are you a carer? Yes ☐ No ☐
Who for:
Children ☐ Elderly relative ☐ Other ☐

Please specify: .....

Who is caring for them currently?

Family	☐	Social Worker	☐
Nursing Home	☐	Neighbour	☐
Respite Centre	☐	Other	☐

Please specify:

Describe Family Living Arrangements

maisonette upstairs & dan/s

Type of House .....

Steps at entrance	☐	How many?	.....
Stairs inside	☐	How many?	.....
Toilet: Upstairs	☑	Downstairs	☐
Bedroom: Upstairs	☐	Downstairs	☐
Banister	☑	Others	.....

.....

Comments

painter & decorator by trade / self employed

Community Services in Use		Frequency	Informed of Admission	Informed By / Comments
Home Care provided	Yes ☐ No ☐		Yes ☐ No ☐	
Meals on Wheels	Yes ☐ No ☐		Yes ☐ No ☐	
Sheltered Housing	Yes ☐ No ☐		Yes ☐ No ☐	
Day Hospital	Yes ☐ No ☐		Yes ☐ No ☐	
Community Nurse	Yes ☐ No ☐		Yes ☐ No ☐	
Community Psychiatric Nurse	Yes ☐ No ☐		Yes ☐ No ☐	
Learning Disability Nurse	Yes ☐ No ☐		Yes ☐ No ☐	
Visited by Specialist Nurse	Yes ☐ No ☐		Yes ☐ No ☐	
Specify:				

Functional Assessment of Medication Use: **Complete for all patients**

Pre-Admission Status			
Independent ☐	Prompting required ☐	Assistance required ☑	
Level ..... MAR Chart ☐	Compliance aid ☐	.....	
On Admission Initial Assessment			
Independent ☐	Prompting required ☐	Assistance required ☑	
Level ..... MAR Chart ☐	Compliance aid ☐	.....	

Do community nurses assist in medicine administration? Yes ☐ No ☐

If Yes, please provide details e.g. insulin administration .....

.....

Nurse Initials: ..... Date: 24/8/17

Remember to re-assess patient needs and service requirements pre-discharge

Multi-Disciplinary Discharge Plan

To ensure safe and timeous discharge planned in partnership with the patient/carer and staff.

PATIENTS SHOULD BE CONSIDERED FOR CRITERIA LED DISCHARGE IF USED APPLY STICKER TO MDT DISCHARGE SUMMARY.

Write or attach label

HCR No:.....
CHI No:.....
Surname:.....
Forename:..... Sex:.....
Address:.....
.....
Date of Birth.....

Estimated discharge date:..... Medically fit date:..... Ready for discharge: .....

Date & Time	Reason for EDD change	New EDD	Initials

Discharge planning should be commenced on the day of admission

Date		Yes	No	N/A	Int
	Does the patient require a discharge planning meeting?				
	If yes to the above contact patient, family, social work and members of the MDT Record date of meeting...../Outcome.....				
	Discuss, document and agree discharge plan with patient, relatives, carers and MDT				
	Equipment needed. **Please document on checklist over page.**				
	Does the patient have house keys Key safe number:				
	Does the patient have appropriate clothing for discharge				
	Does the patient require a **Fit Note**				
	Has the patient been given a **Fit Note**				
	Does the patient require a home visit or environment assessment				
	Continuing care at home	Yes	No	N/A	Int
	Referred to ICES☐ Homecare☐ Occupational Therapy☐ Physiotherapy☐				
	Homecare referral type New referral☐ Increase☐ Restart☐				
	Level of Homecare Package				
	Homecare confirmed by..... Start Date & Time.....				
	Community nurse referral made ☐ Referred to Podiatry ☐				
	Discharge Medication/Aids	Yes	No	N/A	Int
	Order discharge prescription **(Consider Blister pack or MAR chart)**				
	Discharge prescription is on the ward				
	7 day supply of dressing, continence aids, catheters or stoma products (new patients must be given a 7 day supply and refer to district nurse for re-assessment)				
	Nutritional Supplements/Enteral Feed/Thickener: new patients must be given a 7 day supply				
	Transport Those able to make their own travel arrangements should be encouraged to do so	Yes	No	N/A	Int
	Own transport arrangements:				
	Hospital transport booked. Ambulance ☐am ☐pm **Reference No:**				
	Discharge Lounge	Yes	No	N/A	Int
	Is the patient suitable for the discharge lounge (Ext XH 26467 / 8) (Ayr 17078)				
	Plans in place to facilitate morning discharge **If no document why**				

MDT Discharge Plan

	Final checklist Please complete all sections of this checklist on discharge	Yes	No	N/A	Int
	Cannula removed				
	Patients own medication returned				
	Discharge prescription given and explained to patient/carer				
	Clinic follow up arrangements given. (Please record in discharge summary)				
	Patients property packed and valuables returned				
	If DNACPR keep copy in patients notes and send original home				
	Send home "Getting to Know Me" document if appropriate				
	Anticipatory Care Pathway or any other relevant community plan/pathway?				
	Inform family/NOK/carer when patient leaves the ward (If appropriate)				
	If appropriate the patient and their carer are provided with the NHS Preventing Pressure Ulcers: A guide for Adults at risk of Pressure Ulcers leaflet.				

MDT Discharge Plan

Equipment needs; essential equipment should be in place for discharge				
Equipment type	Date Requested	Arranged by	Expected delivery date	Delivery confirmed
Physio (specify)				
OT (specify)				
Commode				
Hospital Bed*				
Pressure Reducing Mattress*				
Chair Cushion				
Wheelchair				
Oxygen Cylinder and/or Concentrator				
Enteral Feeding Equipment				
Community alarm				
Key safe				
Other (specify)				

* Please call the district nurse to discuss before ordering.

Multi-Disciplinary Discharge Summary

Date & Time	This should include reference to SSA, 24hr continuing care or rehab	Initials

MDT Discharge Plan

Multi-Disciplinary Discharge Summary

Date & Time	This should include reference to SSA, 24hr continuing care or rehab	Initials

Lifestyle Assessment/Usual Ability

HC XH-16-048324-1
CH DOB: 14/06/1965 Male
Sur GALLOWAY Stephen
For 28 REDBURN PLACE, IRVINE
Adc KA12 9BH
Date

Pre-admission Status Communicating	Initial assessment Detail Presenting Problems/Risk/Needs
Any specific communication needs: Speaking Yes ☐ No ☑ Reading Yes ☐ No ☑ Writing Yes ☐ No ☑ Glasses Yes ☑ No ☐ Contact Lenses Yes ☐ No ☐ Hearing aid - Left ☐ with Patient ☐ Hearing aid - Right ☐ with Patient ☐	Interpreter required** Yes ☐ No ☑ wears glasses all the time. no problems with hearing
Breathing	**Detail Presenting Problems/Risk/Needs**
Do you normally have any issues with breathing? Yes ☐ No ☑ If yes, please describe..... ..... Equipment / aids - circle all that apply: Inhalers / oxygen -concentrator / cylinder / nebulisers / tracheostomy. Do you smoke? Yes ☑ No ☐ If so how many..... All smokers *must* be referred to Fresh Air-shire for discussion about smoking management whilst in hospital; this will include being advised about the current smoking policy. Please attach a patient sticker to referral card and place it in the Fresh Air-shire referral box on the ward. For any queries please phone Fresh Air-shire on 08007 839132. Please tick when this referral has been made ☐ Date & time of referral.....	no problems with breathing smokes roll up 12-15 cigarettes Patient wishes nicotine replacement therapy? Yes ☐ No ☑ Should a patient insist on leaving the ward for a cigarette, a smoking disclaimer must be completed. Smoking disclaimer signed Yes ☐ No ☐
Mobilising/Falls Risk Assessment	**Detail Presenting Problems/Risk/Needs**
Does the patient normally have a reduced functional ability Yes ☐ No ☐ Walking aids Yes ☐ No ☐ Pain Yes ☑ No ☐ Foot Problems Yes ☐ No ☐ Poor balance Yes ☐ No ☐ Uncoordinated movements Yes ☐ No ☐ Medication that could increase risk (refer to page 29) Yes ☐ No ☐ Falls History Yes ☐ No ☐ Cognitive Impairment Yes ☐ No ☐ Sensory Problems Yes ☐ No ☐ Is patient at risk of falling from bed? Yes ☐ No ☐	independant pain at back of neck. Is the patient at risk of falls?* Yes ☐ No ☑

* Consider increasing frequency of intentional rounding
* Consider higher level supervision policy
** Language Line 0845 310990 ID No L28656

Lifestyle Assessment

Lifestyle Assessment

Lifestyle		Yes	No
Driving Status	Do you Drive	☐	☑
Physical Activity	How many days per week do you usually undertake a total of 30 minutes or more exercise? 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☑ NA☐ If less than 5 days, does this equal more than 2½ hours of activity a week If no would you like support to increase your activity level	☑ ☑	☐ ☐
Alcohol Use	Units per week occasional beer during week. — sometimes case beer now and age. Suitable for alcohol brief intervention? ☐ Not applicable Currently in Treatment? ☐ Not applicable Refer to Substance misuse service? ☐ Not applicable	☐ ☐ ☐	☐ ☐ ☐
Substance misuse	Substance misuse issues/? If yes give details: Currently in treatment? ☐ Not applicable Refer to substance misuse? ☐ Not applicable	☐ ☐ ☐	☑ ☑ ☑

Pre Admission Status	Initial assessment
Eating and Drinking	**Detail Presenting Problems/Risk/Needs**
Does the patient need assistance in carrying out their own basic oral care? Yes☐ No☑	
Does the patient have dentures? Yes☐ No☑ Top☐ Bottom☐ Partial☐ With Patient☐	no problems with teeth
Is the patient suffering from mouth pain? Yes☐ No☐	
Patient on nutritional supplements / enteral feed at home? Yes☐ No☐	
Type: _____	no special diet.
Amount _____	used to wimold wheat
Frequency _____ kitchen notified Yes☐ No☐	but eats bread now.
Any changes in eating pattern/appetite? Yes☐ No☐	Appetite poor recently.
Specify: _____	not eaten since Sunday.
Support required for eating/drinking? Yes☐ No☐	
Equipment required to support eating /drinking Yes☐ No☐	
Likes _____	
Dislikes peas and butter beans	
Long term swallowing ability impaired (Consider referral to SLT) Yes☐ No☑	
Modified Diet/Fluids Texture..... Stage.....	
Consent to therapeutic diet (Cultural/Ethic/Religious requirements) Yes☐ No☑	
Complete MUST Screening on page 20.	
Eliminating	**Detail Presenting Problems/Risk/Needs**
Normal bowel habit Yes☑ No☐	
When did your bowels last move? ..... 24/8/16.....	regular
Any problems passing urine? Yes☐ No☑	
Does the patient have a urinary catheter in situ Yes☐ No☑	If YES apply the Catheter Care Bundle
Date of catheter insertion _____	
Long term catheter? Yes☐ No☑	
Complete continence assessment if required	
Refer to Adult Continence Assessment Pathway algorithm	Referral Date: _____

XH-16-048324-1
HCI
CHI DOB: 14/06/1965 Male
Sur GALLOWAY Stephen
For 28 REDBURN PLACE, IRVINE
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Dat

Pre Admission Status	Initial assessment
Personal Cleansing & Dressing	**Detail Presenting Problems/Risk/Needs**
Is patient normally independent? Yes ☑ No ☐ What type of assistance is required by the patient (please consider patient preferences)	Self caring
Skin Condition	**Detail Presenting Problems/Risk/Needs Preliminary Pressure Ulcer Risk Assessment (PPURA)**
Date 24/8/16 Time 1690 **Mobility** Patient is fully mobile without equipment / assistance Yes ☑ No ☐ **Continence** Patient is fully continent Yes ☑ No ☐ **Nutrition** Patient appears to be well nourished and able to eat and drink Yes ☑ No ☐ **Skin** Skin is healthy and intact Yes ☑ No ☐	Assess condition of skin, any wounds / lesions / stomas If No to any questions undertake Waterlow Assessment and apply the SSKIN bundle if indicated. Daily assessment are per careplan N
Spiritual or religious needs	**Detail Presenting Problems/Risk/Needs**
Faith or Life Stance? Do you have any spiritual or religious needs whilst in hospital? *(please state)* Yes ☐ No ☑ Do you wish your details passed to the hospital Chaplaincy Service? Yes ☐ No ☑ Do you wish your own Minister/Priest contacted Yes ☐ No ☑ If yes complete name & telephone number Name..... Tel No..... Specify needs or cultural practices that place limitations on the patient's care *(please state)*	

Lifestyle Assessment

Patient Risk Assessment

Write or attach label

HCI XH-16-048324-1
CHI
Surn DOB: 14/06/1965 Male
Fore GALLOWAY Stephen
Add 28 REDBURN PLACE, IRVINE KA12 9BH
Date

1406650854

After completing the Individual Person Centred Lifestyle Assessment please now decide which risk assessments your patient needs.

In some circumstances your professional judgement may decide that this patient is exempt from a particular mandatory assessment. You must clearly document the reason for this decision.

Identify relevant assessment tools and tick the box to confirm assessment tool activated.

Yes	N/A		
☑	☐	**MRSA**	**mandatory**
☑	☐	**Nutrition - MUST**	**mandatory**
☐	☑	**Oral Health**	**if clinically indicated**
☑	☐	**Pressure Area Care - Waterlow**	**Mandatory if PPURA indicates needs**
☑	☐	**Falls**	**Over 65/history of falls**
☑	☐	**Bedrails**	**mandatory**
☑	☐	**Moving and Handling**	**mandatory**

You may use your professional judgement to decide which assessment tools are most relevant to your patient. It may not be necessary to complete all risk assessments for every patient.

Not Completed		Reason Why
☐	**MRSA**	
☐	**Nutrition - MUST**	
☑	**Oral Health**	able to attend to oral hygiene
☐	**Pressure Area Care - Waterlow**	
☐	**Falls**	
☐	**Bedrails**	
☐	**Moving and Handling**	

It will be necessary to re-assess the requirement for completion of the above risk assessments during the patients stay

Nurse Initials: Due Date: 29/8/16

NHS Ayrshire & Arran

Completed in Ward CAU

Infection Prevention & Control Assessment

Risk Assessment 1 - MRSA Clinical Risk Assessment (CRA) ⚠ **REMEMBER to check for alert on PMS**

	Y	N	unknown	Action	Date	Initial
Has the patient had any **previous history of MRSA** colonisation or MRSA infection at any time in the past?		✓		• **Any** of the three questions answered **'YES'** Screen **nose and perineum** (& wound or device where applicable)		
Is the patient currently **resident in a care home or Institutional setting** (ie prison, homeless, hostel) or **transferred from another hospital?**		✓		• Manage patient as if MRSA positive (isolate if possible)		
				• Complete next section of the CRA **All** three of the questions **'NO' or 'unknown'** • No action required, **All direct admissions to the 4 high risk specialties (renal, orthopaedics, vascular / cardiothoracic, intensive care) should be routinely screened.**		
Does the patient **have a wound/ulcer or indwelling medical device** which was present before admission to this hospital?		✓		• Screen from **nose and perineum** (& wound or device where applicable) regardless of the outcome of answering the 3 questions above. **ALL PATIENTS MUST HAVE CRA COMPLETE FOR PRE-EMPTIVE ISOLATION PURPOSES**		

Risk Assessment 2 - Loose stool risk assessment for CDI and Novovirus

	Y	N	unknown	Action	Date	Initial
Patient: Presenting at admission with loose stool and/or vomiting		✓		If **YES,** Isolate patient and complete full loose stool risk assessment with Bristol stool chart and send sample to virology and bacteriology. Vomit may be sent to virology for novovirus testing (when 2 or more cases in the ward)		
Has been transferred from any ward/nursing home with suspected or confirmed cases of novovirus		✓				

Risk Assessment 3 - Multi drug resistant organism eg Carbapenemase-producing Enterobacteriaceae (CPE)

	Y	N	unknown	Action	Date	Initial
Has the patient either been transferred from a hospital outside Scotland or been hospitalised outside Scotland in the last 12 months? If yes, state		✓		**Any** of the questions answered **'YES'** • Screen **rectum** (& wound or device where applicable) OR faecal specimen		
				• Manage patient as if CPE positive (isolate if possible)		
				All questions **'NO' or 'unknown'** • No further action. **IN THE INVESTIGATIONS BOX ON THE LABORATORY REQUEST FORM PLEASE REQUEST "CPE SCREENING". ALSO IDENTIFY THE COUNTRY IN WHICH THE PATIENT WAS HOSPITALISED IF APPLICABLE.**		
Has the patient been previously positive for CPE at any body site?		✓				

Always contact Infection Prevention & Control Team (ext 25765) or Consultant Microbiologist Oncall (via switchboard) for further advice as required.

Risk Assessment

Risk Assessment

NHS Ayrshire & Arran

XH-16-048324-1
HCR Nı DOB: 14/06/1965 Male
CHI No GALLOWAY Stephen
Surnam 28 REDBURN PLACE, IRVINE
Forenan KA12 9BH
Address
Date of Birth

Nutritional Screening 'Malnutrition Universal Screening Tool' ('MUST')

Food Fluid and Nutrition

Step 1: Measure height and weight to get a BMI score.
Step 2: Note percentage unplanned weight loss and score.
Step 3: Establish acute disease effect and score.
Step 4: Add scores from steps 1, 2 and 3 together to obtain overall risk of malnutrition.
Step 5: Follow the management guidance appropriate to the risk category and commence the corresponding care plan.

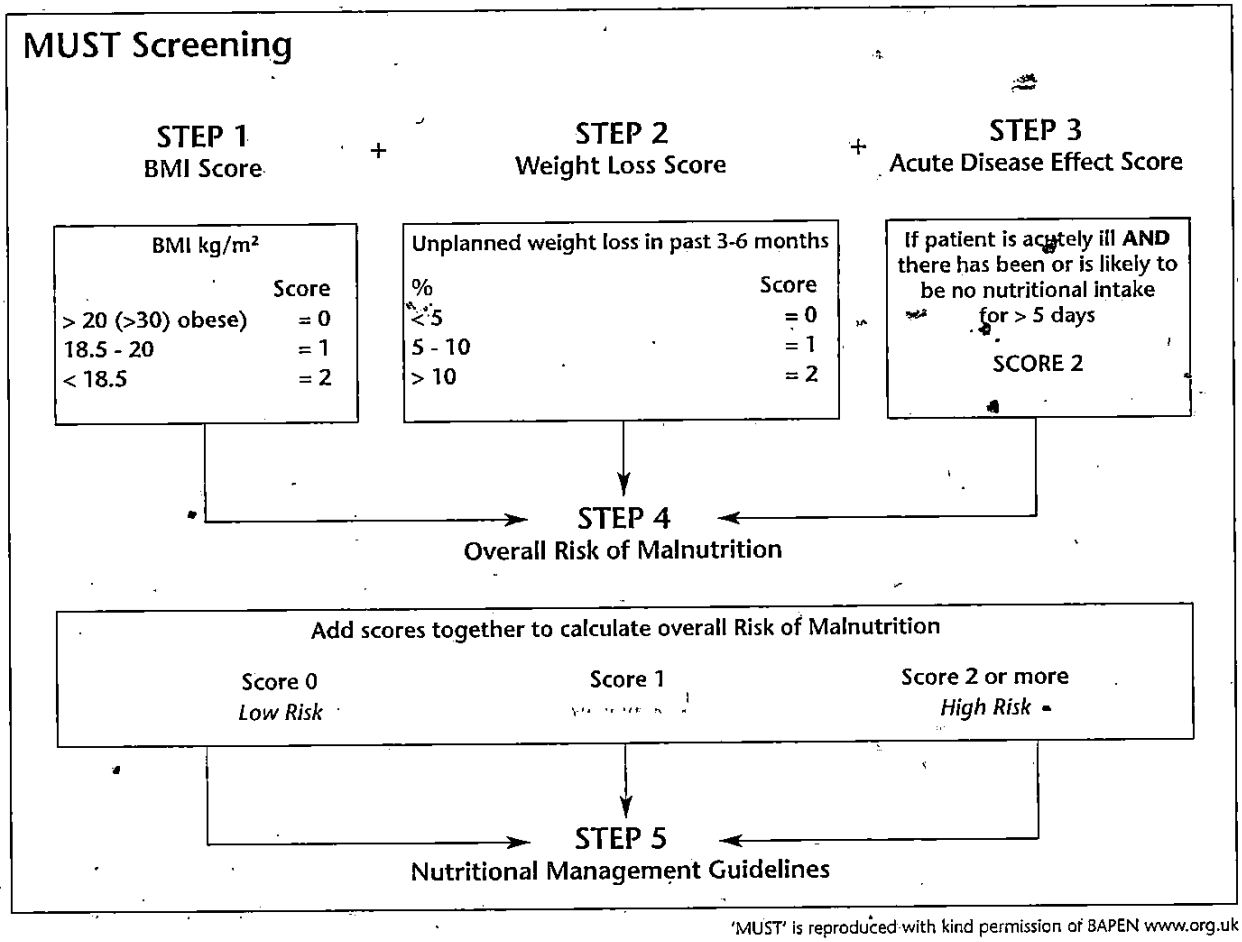
Screening Results

Please indicate if measurements are Measured (M), Reported (R) or Estimated (E)

Date	24/8/16				
Time	24/8/16				
Ward	1690				
Height (metres) (M)( ) (R)( ) (E)( )	5ft 5 m	m			
Current weight (Kg) (M)( ) (R)( ) (E)(✓)	11.4kg ( )	Kg ( )	Kg ( )	Kg ( )	Kg ( )
BMI	25				
Is patient within obese category?					
Usual weight (Kg)	Kg				
Signature	O'Neill				
MUST					
Step 1: BMI Score >20 (>30 = Obese) ..... 0 18.5 - 20 ..... 1 < 18.5 2	0				
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months. <5% ..... 0 5 - 10% ..... 1 >10% 2	0				
Step 3: Acute Disease Effect Score If patient is acutely ill **and** there has been or is likely to be no nutritional intake for>5 days.....Score 2 Not applicable .....Score 0	0				
Step 4: Overall Risk of Malnutrition Total:					
Step 5:	0 = Low Risk	1 = Medium Risk	2 or more = High Risk		

Referrals	Consent for referral obtained	Date referred	Signature
Dietician	☐		
Speech and Language Therapy	☐		

MUST Screening



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Nutritional Management Guidelines:

MUST Score 0	MUST Score 1	MUST Score 2 or more
Low risk - *Routine Clinical Care* • Commence and implement the **Low Risk Care Plan** • Monitor and review care plan • **Repeat screening as below:** Acute..... weekly Continuing Care..... monthly	Medium risk - *Observe* • Commence and implement the **Medium Risk Care Plan** • Monitor and document dietary intake whilst in ward/department on a Food Record Chart • Encourage oral intake • Assist patient to choose appropriate meals/snacks and offer milk or suitable alternative to drink with and between meals. • Provide nutrition information leaflet to patient. • Monitor and review care plan • **Repeat screening weekly or when next in department.**	High risk - *Treat** • Commence and implement the **High Risk Care Plan** • Refer to Dietitian, include MUST score • Continue to monitor dietary intake. • Offer maximum encouragement. • Monitor and review care plan • **Repeat screening weekly or when next in department.** • Consider use of red tray/jug *Unless detrimental or no benefit is expected from nutritional support e.g. imminent death. Use own judgement and document rationale for not treating.

- For low risk patients implement interventions in the **green** section of the care plan, as appropriate.
- For medium risk patients implement interventions in the **green** and yellow sections of the care plan.
- For high risk patients implement interventions in the **green,** yellow and **red** sections of the care plan.
- Always use your own professional judgement when screening patients and making referrals.
- Consider initial admission information relating to eating and drinking needs and preferences.
- When completing Step 2 always compare the most recent weight with the 'usual' weight (or use the initial weight taken on admission if necessary) and not the previous weeks weight.

NHS Ayrshire & Arran

Malnutrition Universal Screening Tool ('MUST') Multidisciplinary Care Plan

HCR N XH-16-048324-1
CHI N DOB: 14/06/1965 Male
Surnar GALLOWAY Stephen
Forena 28 REDBURN PLACE, IRVINE
Addres KA12 9BH
Date of

Patient Problem
Nutritional screening has identified the patient as being Low ■ Medium ☐ High ■ Risk of malnutrition
Patient identified as having other nutritional problems e.g. obesity, chewing certain foods (specify)

Goal
To meet patients nutritional and fluid requirements

Date	Time	Intls	Planned Nursing Interventions/Support	End Date	Intls
24/8/14	1690	DMC	**Low Risk Care Plan**		
			Assistance required (specify) e.g. helping, prompting, cutting up food, opening packets:-		
			Individual / therapeutic dietary requirements (specify) e.g. likes/dislikes religious/ethical/cultural:-		
			Modified eating equipment (specify) e.g. cutlery.		
			Assist patient to select appropriate meals from menu card.		
			Ensure fresh drinking water is offered regularly and available at all times, where clinically appropriate.		
			Consider patients positioning and support oral hygiene, if required.		
			Ensure patients nutritional needs recorded on nutrition board e.g. food chart.		
		✓	Monitoring and review care plan **repeat screening weekly** (monthly continuing care).		
			Medium Risk Care Plan (complete low risk section		
			Commence food chart for a minimum of 3 days. Only discontinue if/when dietary intake is adequate.		
			If intake is insufficient, offer patient milk to drink with / and between meals and suitable additional snacks.		
			Record accurate fluid intake / output on fluid balance chart until established that oral intake is adequate. If intake per 24 hours is inadequate consider IV/SC fluids.		
			Monitor and review care plan and **repeat screening weekly.**		
			RED TRAY Yes ☐ No ☐ RED JUG Yes ☐ No ☐		
			High Risk Care Plan (complete low and medium risk section also)		
			Refer to Dietitian, ensuring the MUST score is included.		
			Discontinue food chart only when advised by Dietitian.		
			Administer and monitor enteral feed via NG/PEG route as per local guidelines.		
			Monitor and review care plan and **repeat screening weekly.**		
			This care plan has been discussed and agreed with the patient as appropriate.		

Risk Assessment

Following assessment the Speech and Language Therapist will recommend which texture is suitable for the Individual	
Modified Food Consistency	
Texture B Thin Puree	Smooth consistency with no lumps Can be poured Will slowly drop through prongs of a fork **Thick enough to stand a light plastic teaspoon in**
Texture C Thick Puree	Smooth, moist consistency with no lumps and should not be sticky on palate Cannot be poured Holds its shape on the plate when scooped **No separation of fluids**
Texture D Pre-mashed	Mashed or finely minced before serving Very soft, tender and moist Needs very little chewing **No mixed textures or separation of fluids**
Texture E Fork Mashable	Food must be able to be mashed with a fork Soft, tender and moist Needs some chewing **Meat must be very soft and tender, or minced in thick sauce**

Modified Fluid Consistency	
Stage 1 **Syrup consistency**	Use 1 level scoop of Nutilis Clear in a 200ml drink • This leaves a thin coat on the back of a spoon
Stage 2 **Custard consistency**	Use 2 level scoops of Nutilis Clear in a 200ml drink • This leaves a thick coat on the back of a spoon
Stage 3 **Pudding consistency**	Use 3 level scoops of Nutilis Clear in a 200ml drink • This needs to be taken with a spoon • This will be too thick to drink from a cup

Please record any Therapeutic/Special Diet/Fluids

Texture/Stage/Type (include diabetic, gluten free etc)	Date commenced	Comments	Date discontinued

Please Record if Patient on / Commenced on Supplements
If on supplements please commence supplement monitoring chart

Supplement	Frequency	Any preferences / dislikes	Supplement Chart	On Nutrition Board	Stopped

Any additional interventions (free text)

Further information can be found in the Dietetic Treatment Record

NHS Ayrshire & Arran

Oral Health Risk Assessment (Review 4 - weekly)

Rapid Assessment Questions	Circle which is appropriate		Suggested outcome/actions if "Yes" circled
Does the patient need assistance in carrying out their own basic oral care?	Yes	No	If you have answered yes to any of these questions please complete full oral health risk assessment below and review 4-weekly
Does the patient have dentures?	Yes	No	
Is the patient suffering from mouth pain?	Yes	No	
What is your normal mouth care routine at home? (for initial assessment only)	Details		
When did you last see a dentist? **(If more than 5 years, refer to dentist)**	Details		
Are you having any problems with your teeth or mouth?	Details		

Patient Assessment		Circle which is appropriate		Suggested outcome / actions if "Yes" circled
Smoking habits	Smoker? (which may increase risk of gum disease and oral cancer	Yes	No	Note amount per day on profile Refer to fresh air-shire for smoking management
Dexterity problems	Having difficulty holding toothbrush?	Yes	No	May need supervision/help with mouth care Consider OT adaptation
Cognitive function	Evidence of short-term memory loss and/or confusion?	Yes	No	May need supervision/help with mouth care
Oral Assessment - use tongue compressor and pen torch to examine oral cavity		**Circle which is appropriate**		**Suggested nursing care if "Yes" circled**
Lips	Dry/cracked?	Yes	No	Apply an emollient e.g. lubricating gel
Tongue	Dry/coated?	Yes	No	Clean with soft toothbrush and toothpaste Offer frequent fluids
	Evidence of ulceration/soreness?	Yes	No	**If yes, refer to Salaried Dental Services (SDS)* or advise patient to contact their dentist on discharge**
Gums/soft tissue	Evidence of soreness, ulceration, bleeding gums or whiteness?	Yes	No	**If yes, refer to SDS* or advise patient to contact their dentist on discharge**
Saliva	Dry mouth? (xerostomia) could be side-effect of medication e.g. antidepressants, anticonvulsants etc.	Yes	No	Offer frequent fluids and/or iced water If symptoms persist refer to dentist
Teeth	Natural top teeth?	Yes	No	Encourage independence with cleaning teeth night and morning. Use toothbrush and fluoride toothpaste (see Basic Oral Care Guideline for concentration of fluoride)
	Natural lower teeth?	Yes	No	
	Evidence of plaque / debris?	Yes	No	Supervise/help with oral care Use toothbrush and fluoride toothpaste
Dentures	Top denture?	Yes	No	Supervise/help with cleaning dentures night and morning with mild soap and water; rinse dentures after meals. Clean teeth as above
	Lower denture?	Yes	No	
	Dentures and natural teeth?	Yes	No	Remove dentures at night and leave to soak in water with Milton
	Denture marked with patient's name?	Yes	No	If no, refer to SDS" for marking
Pain	When eating / drinking?	Yes	No	**If yes, refer to SDS* or advise patient to contact their dentist on discharge**
	Caused by teeth / dentures?	Yes	No	
Swallowing	Difficulty with swallowing?	Yes	No	Supervise/help with cleaning teeth and/or dentures and oral cavity after each meal
Nutrition	NBM / Fluid/dietary intake poor?	Yes	No	May require 2 hourly mouth care
	Dehydrated?	Yes	No	Check whether oral problems contributing
	On energy-dense diet or prescribed supplements/snacks?	Yes	No	Consider high fluoride toothpaste if have natural teeth (2800ppm F)

Initials .....

Designation .....

Dental Services Helpline 01563 578 664
For urgent care or advice on weekdays

NHS 24: 111
For dental emergencies out-of-hours

Risk Assessment

Oral Hygiene - Care Plan

Write or attach label

HCR No:.....
CHI No:.....
Surname:.....
Forename:..... Sex:.....
Address:.....
.....
Date of Birth.....

Pre Admission Status					
Patient has undergone oral assessment and requires assistance with regular mouth care					
Goal					
For oral cavity to be clean, pink, moist and comfortable					
Date	**Time**	**Intls**	**Planned Nursing Interventions**	**Discontinued Date/Time**	**Initials**
			Dental Referral		
			• If patient hasn't seen a dentist • If patient suffers from mouth pain • If evidence of ulceration/soreness on tongue • If evidence of ulceration, bleeding gums or whiteness in gums/soft tissues		
			Oral Care		
			If patient is able, prompt by providing adequate opportunity and support to carry out oral care.		
			If patient is dependent, ensure mouth care is offered and provided at regular intervals.		
			If patient has dentures supervise/help with cleaning them night and morning with mild soap and water; rinse dentures after meals. Dentures should be left out and soaked in sodium hypochlorite overnight or for at least 20 minutes, before rinsing and leaving in plain water for the rest of the time. Metal-based dentures should be soaked in chlorhexidine mouthwash.		
			Other Issues		
			If lips are dry apply emollient e.g. lubricating gel.		
			If tongue is dry and coated clean with soft toothbrush and toothpaste and offer frequent fluids.		
			If patient suffers from dry mouth offer frequent fluids and/or iced water. If symptoms persist refer to dentist.		
			If patient has difficulty swallowing you should supervise/help with cleaning teeth and/or dentures and oral cavity after each meal.		
			If patient is nil by mouth or has poor fluid or dietary intake or is dehydrated they may require 2-hourly mouthcare. Check whether oral problems contributing.		
			If patient is on an energy dense diet or prescribed supplements/snacks consider high fluoride toothpaste if have natural teeth.		
			This care plan has been discussed and agreed with the patient as appropriate.		

Risk Assessment

NHS Ayrshire & Arran

Adapted Waterlow Pressure Area
- Risk Assessment Chart

More than one score can be used in each section

Complete assessment according to PPURA or if there is a change in individual's condition and repeat regularly according to local protocol

HCR N XH-16-048324-1
CHI N
Surnai DOB: 14/06/1965 Male
Forenz GALLOWAY Stephen
Addre 28 REDBURN PLACE, IRVINE
KA12 9BH
Date c
1406650854

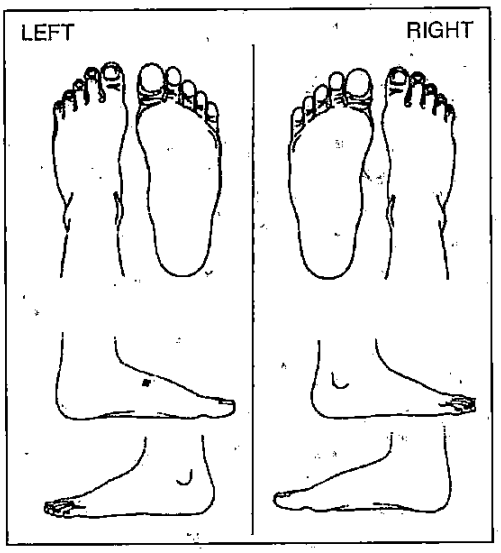
Risk Assessment

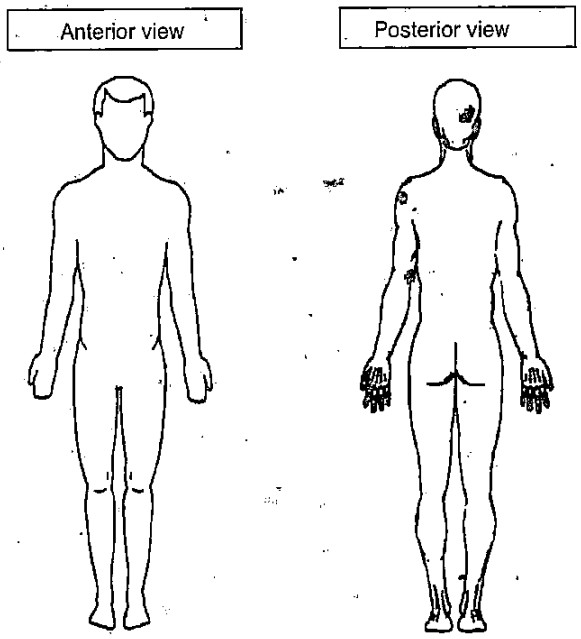
		Date	24/8									
		Time	1645									
Sex												
Male 1	Female 2		1									
Age												
14 - 49		1										
50 - 64*		2										
65 - 74		3	2									
75 - 80		4										
81+		5										
Build/Weight for Height *(BMI=weight in Kg/height in m²)*												
Average - BMI 20-24.9		0										
Above average - BMI 25-29.9		1	1									
Obese - BMI > 30		2										
Below average - BMI < 20		3										
Continence												
Complete/catheterised		0										
Urinary Incontinence		1	0									
Faecal incontinence		2										
Urinary and faecaly incontinent		3										
Skin Type - Visual Risks Area												
Healthy		0										
Tissue paper (thin/fragile)		1										
Dry (appears flaky)		1	0									
Oedamatous (puffy)		1										
Clammy (moist to touch) pyrexia		1										
Discoloured/Bruising/Grade 1		2										
Broken (established ulcer) Grade 2 - 4		3										
Mobility												
Fully mobile		0										
Restless/fidgety		1										
Apathetic (sedated/depressed/reluctant to move)		2										
Restricted (restricted by severe pain of disease)		3	0									
Bedbound (unconscious/unable to change position/traction)		4										
Chairbound (unable to leave chair without assistance)		5										
Special Risks - Tissue Malnutrition												
Multiple organ failure/terminal cachexia		8										
Single organ failure e.g. cardiac, renal, respiratory		5										
Peripheral vascular disease		5										
Anaemia = Hb < 8		2	0									
Smoking		1										
Special Risks - Neurological Deficit												
Diabetes/MS/CVA/motor/sensory/paraplegia	*Max 6*	4-6	0									
Special Risks - Surgery/Trauma												
On table > 2 hours (up to 48 hours post op)		5										
On table for up to 6 hours (up to 48 hours post op) provided the rate of recovery is normal)		5	0									
Orthopaedic/below waist/spinal		8										
Special Risks - Medication												
Cytotoxic, anti-inflammatory, long term/high dose steroid	*Max 4*	4	0									
		Total Score	4									
		Initials	DM									

<10 Low Risk - Reassess weekly	• The Waterlow **must be reassessed** if the patient's condition changes /deteriorates and the plan of care should be reviewed at that point.
10+ At Risk - Reassess twice weekly	• For patients who are in long term care, provided their condition is stable after one week of admission the Waterlow can be reassessed weekly/monthly
15+ High Risk - Reassess on alternate days	
20+ Very High Risk - Assess daily	

Pressure Ulcer Record

Indicate by circling, numbering and dating all pressure damage on diagrams, then complete box below.
Initiate SSKIN can plan/wound assessment chart.





Date	Number of ulcer	Location of ulcer	Grade of ulcer	Datix Insert reference Grade 2-4	Logged on safety cross Grade 1-4	Signature	Print name

Risk Assessment

<u>Scottish Adapted European Pressure Ulcer Advisory Panel) EPUAP - Pressure Ulcer Grading Tool - 2014</u>

GRADE 1 Intact skin with non blanchable redness, usually over a bony prominence. Darker skin tones may not have visible blanching but the colour may differ from the surrounding skin. The area may be painful, firmer, softer, warmer or cooler than the surrounding tissue.

GRADE 2 Loss of epidermis/dermis presenting as a shallow open ulcer with red/pink wound bed without slough or bruising. May also present as a blister.

GRADE 3 Subcutaneous fat may be visible but bone tendon or muscle is not visible or palpable. Slough may be present but does not obscure the depth of tissue loss. Often includes undermining or tunnelling

GRADE 4 Extensive destruction with exposed or palpable bone, tendon or muscle. Slough may be present but does not obscure the depth of tissue loss. Often includes undermining or tunnelling.

DEEP TISSUE INJURY Epidermis is intact but the area appears purple or maroon or is a blood filled blister over a dark wound bed. Over time the skin will degrade and develop into deeper tissue loss.

UNGRADABLE: Full thickness skin loss where the depth of the ulcer is completely obscured by slough/necrosis. Until enough slough or necrotic tissue is removed to expose the base of the wound the true depth cannot be determined. It may be a grade 3 or 4 once debrided.

All acquired pressure ulcers graded 2 - 4 must be reported via Datix.
Refer to podiatry for at risk feet.

Slips Trips & Falls Assessment Tool

XH-16-048324-1

HCR N DOB: 14/06/1965 Male
CHI N GALLOWAY Stephen
Surna 28 REDBURN PLACE, IRVINE KA12 9BH
Foren
Addre
1406650854
Date of Birth

Date of admission: 29/3/16

Please assess ALL patients with a history of falls or over 65 years or if clinically indicated
Each category must be filled in
If the patient does not meet any of the criteria, N/A to be entered in box
You can have more than one score for some categories

Risk Assessment

	Ward Name: Assessment Date and Time of Day	Date: 29/3 Time: 1600	Date: Time:	Date: Time:	Date: Time:	Date: Time:
ITEM	**SCORE**	**SCORE**	**SCORE**	**SCORE**	**SCORE**	**SCORE**
GENDER	1 = Male 2 = Female	1				
AGE	1 = 16-70 years 2 = 71-80 years 3 = 81 + years	1				
GAIT/MANNER OF WALKING (with usual aid)	1 = Hesitant 3 = Unsteady / Falls back / Unable to walk	0				
COGNITION	3 = Any degree of disorientation	0				
SENSORY	1 = Poor hearing 1 = Poor sight 2 = Poor balance 2 = Uncoordinated limb movement or loss of sensation in lower limb	0				
FALL HISTORY	1 = Fall(s) in street 1 = Fall(s) in the ward 1 = Fall(s) at home	0				
MEDICATIONS (see over for examples)	1 = Sedation/analgesics 1 = Tranquillisers 1 = Cardiovascular drugs 1 = Bladder medication	0				
MEDICAL HISTORY (see over for examples)	1 = Altered endocrine/electrolyte balance 1 = Neurological Disorders 1 = Other (i.e. arrhythmias, blackouts etc) 1 = Incontinent of urine and/or faeces	0				
ACTIVITY AND MOBILITY	1 = Independently mobile with or without usual aid 2 = Needs assistance and/or supervision with transfers or mobility 2 = Needs the assistance of 1-2 people to transfer to toilet/commode 3 = Bed/chair bound but moves/rolls unsafely	1				
	TOTAL	3				
Level of Risk	LOW (L) = 0-3 MEDIUM (M) = 9-12 HIGH (H) = [illegible]	LOW				
Initials		DMC				
Print Name		DONNA MCLEOD				
Designation		S/N				

Slips Trips & Falls - Assessment Tool

What happens once you have a score?

- If the patient has scored>6 the appropriate actions should be implemented using the Slips, Trips and Falls care plan
- For low risk patients follow actions in the green section only of the action list
- For medium risk patients follow actions in the green and yellow sections of the action list
- For high risk patients follow actions in the green, yellow and red sections of the action list

Re Assessment Occurs

- Weekly
- When the patient's condition changes (i.e. patient falls/post surgery/change in medication/cognitive state changes)

If the patient has a slip, trip or fall whilst an in-patient, a Datix should be completed and it should also be recorded here.

Slip, Trip or Falls Record (Please complete after each incident)

Date	Time of Day	Location	Injuries?	Circumstances	Datix Number

Medication examples:

SEDATION/ ANALGESICS	TRANQUILLISERS/ ANTIDEPRESSANTS	CARDIOVASCULAR DRUG (those that reduce BP)	BLADDER MEDICATION
• Nitrazepam • Temazepam • Tramadol • Co-codamol	• Risperidone • Haloperidol • Amitryptyline • Alcohol	• Atenolol • Isosorbide Mononitrate • Digoxin • GTN • Diltiazem • Diuretics • Ace-inhibitors	• Doxazosin • Oxybutynin • Tamsulosin (Flomax)

Medical history examples:

Examples of **Altered endocrine/electrolyte balance**	Examples of **Neurological Disorders**	Examples of **"Other"**
• Diabetes • Hyponatraemia • Low calcium • Low potassium	• Parkinson's Disease • Stroke • Head Injury	• Arrhythmias • Osteoporosis • Postural hypo/hypertension • Peripheral Neuropathy • Intermittent heart block • Epilepsy

Risk Assessment

Slips Trips & Falls - Care Plan

(To be used in conjunction with the slips, trips and falls assessment tool)

XH-16-048324-1

HCR I
CHI N
Surna
Forer
Addr
.....
Date

DOB: 14/06/1965 Male
GALLOWAY Stephen
28 REDBURN PLACE, IRVINE
KA12 9BH

1406650854

Problem Number:

Patient Problem/Need
Patient is considered to be at risk of falling

Goal
To promote and maintain patient safety and reduce the risk of falls

Date	Time	Initial		Planned Nursing Interventions	Discontinued Date/Time	Initial
29/8/15	1640	BW		Orientate patient and family/carers to ward environment on admission and each shift.		
				Ensure buzzer within reach.		
				Explain importance about calling for help when needed.		
				Ensure that bedside table and key belongings are within easy reach.		
				Ensure patient wears appropriate clothing and footwear.		
				Ensure that patient is wearing spectacles if appropriate.		
				Discuss with family/carers how to assist with interventions.		
				Ensure that patient/family receives an explanation of risk and the measures in place to minimise this risk and document outcome.		
				Ensure that standard bed frame is used and left in a low position with brakes on.		
				Select a chair that is the appropriate height and design for the patient (seek guidance from Physio and OT).		
				When in use ensure that chair/commode brakes are secure.		
				Ensure that area is illuminated appropriately at night time.		
				Liaise with medical team re: medication review.		
				Consider referral to Physiotherapy, Occupational Therapy, Social Work.		
				Monitor lying and standing blood pressure.		
				Supervise patient when transferring as per moving and handling risk assessment.		
				Supervise patient when mobilising as per moving and handling risk assessment.		

				Offer toileting facilities as appropriate.		
				Ensure that patient is cared for in an area proximal to toilet facilities, if possible.		
				Encourage family, if present, to sit with patient (as appropriate).		
				Encourage family/carers to report to nursing station when ending their visit.		
				Consider appropriate equipment in liaison with Physio and / or OT.		
				Ensure yellow sticker is inserted into patient's notes after each fall.		
				Patients who may be confused or have had repeated falls where possible should be cared for in an area within the ward that is within easy view of nursing staff.		
				Check on patient every 15 minutes.		
				Consider a higher level of supervision of the patient.		
				Consider the use of a low level variable height bed.		

NHS Ayrshire & Arran

XH-16-048324-1
HCR No: DOB: 14/06/1965 Male
CHI No: GALLOWAY Stephen
Surname 28 REDBURN PLACE, IRVINE
Forenam KA12 9BH
Address:
Date of Birth

Bedrails Risk Assessment

Date of admission: 24/8/16

Please assess **ALL** patient on admission to your ward/departments

- Each statement must be answered - Circle answer
- Complete Risk Assessment in conjunction with Bedrails Algorithm overleaf
- Refer to Guidelines - Safe Use of Bedrails in In-patient Settings & Falls Prevention

Re Assessment Occurs

- Weekly
- When the patient's condition changes (i.e. patient falls/post surgery/change in medication/cognitive state changes)

Ensure clear identification of a change in use of bedrails within documentation and at bed space if consent obtained from patient

Risk Factors	Ward: CAD orang Date: 24/8 Time: 1645	Ward: Date: Time:	Ward: Date: Time:	Ward: Date: Time:
1. Is the patient at risk of **falling** from bed?	YES / (NO)	YES / NO	YES / NO	YES / NO
2. Is the patient at risk of **intentionally** climbing over the bedrails?	YES / (NO)	YES / NO	YES / NO	YES / NO
3. Is the patient at risk of **unintentionally** falling from the bed/trolley?	YES / (NO)	YES / NO	YES / NO	YES / NO
4. Does the patient **understand** the purpose of the bedrails? Consider communication difficulties and physical/Cognitive condition.	(YES) / NO / NA	YES / NO / NA	YES / NO / NA	YES / NO / NA
5. Does the patient **consent** to the use of bedrails?	YES / (NO) / NA	YES / NO / NA	YES / NO / NA	YES / NO / NA
Has the Bedrails Algorithm been followed?	Yes ☑ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
According to the Bedrails Algorithm are bedrails required / appropriate?	Yes ☐ No ☑	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Bumpers required	Yes ☐ No ☑	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Initials	[illegible]			

If Yes, commence a Safe Use of Bedrails Care Plan. If No, state reason why bedrails are not required.

Patient independent

Risk Assessment

Bedrails Algorithm

Complete the NHS Ayrshire and Arran Slips Trips and Falls Assessment Tool

Is the patient at risk of falling from bed/trolley?
NB: for patients at risk of climbing over bedrails, alternatives must be considered. See boxes 2+3

Yes

Patient does not understand purpose of bedrails due to .....

Patient understands purpose of the bedrails

- Patient consents to bedrail use → Bedrails could be used with caution. See boxes 1 + 3 below
- Patient declines bedrail use → Bedrails inappropriate see boxes 2+3

Communication difficulties → Consider:
- Referral to appropriate speciality e.g. audiology
- Use of interpreter
- Use of written or pictoral information

Physical and/or cognitive condition → Consider actions in patient's best interest. See boxes 1, 2 + 3 below → Agree plan of care with Next of Kin and document outcome in nursing records

No

- Patient requests bedrails → Bedrails could be used with caution. See boxes 1 + 3 below
- Patient not requesting bedrails → Bedrails inappropriate see box 3

1. If bedrails are used consider:

- Risk of entrapment and harm to limbs
- Risk of patient climbing over the top
- The psychological effect of their use on the patient
- Ensure bed returned to lowest height after care delivery
- Use of the Dynamic mattress increases the height of the bed

2. Alternatives to bed rails

- Use of variable height bed
- Additional mattress/crash mat beside bed
- Close observation of patient
- Ensure bed returned to lowest height after care delivery
- Ensuring patient needs anticipated e.g. drinks are accessible, regular toileting, call bell to hand etc
- Nursing patient on mattress on the floor should be a last resort and safety checks should be made for hot pipes, electric sockets etc. Manual handling risk assessment for staff must be undertaken

3. Remember to document in nursing records:

- Date and time assessment made
- Rationale for decision made in care plan
- Actions taken including discussion with Next of Kin
- Care planning

Assessment should be made:

- On admission
- If patient's condition changes
- Weekly

Risk Assessment

Safe Use of Bed Rails - Care Plan

Write or attach label

HCR No:.....
CHI No:.....
Surname:.....
Forename:..... Sex:.....
Address:.....
.....
Date of Birth.....

Patient Problem/Need
The patient is at risk of falling out of bed due to (e.g. cognitive or physical condition)

Goal
To promote and maintain patient safety and reduce the risk of falling out of bed

Date	Time	Initial	Planned Nursing Interventions	Discontinued Date/Time	Initial
			Ensure assessment is made on admission, when patient's condition changes, and weekly as a minimum.		
			Ensure rationale for decision made re; the use of bedrails is clearly documented.		
			Consider psychological effects of bedrail usage on patient and where appropriate ensure the patient's consent to their use.		
			Ensure risk of entrapment is minimised by careful positioning of patient prior to operating bedrails.		
			If detachable bedrails used, ensure the gap between the top end bedrail and head of bed is less than 6cm or more than 25cm.		
			If detachable bedrails used, ensure the gap between the bottom end of bedrail and foot of bed is more than 25cm.		
			Continually monitor risk of patient climbing over the top of bedrails and assess the use of bedrails as necessary.		
			Discuss with the patient, the need to share information with other nurses and health care workers re; the use of bedrails, and document within the nursing documentation whether the patient consents to display information at the bed space.		
			Provide Falls/Use of Bedrails information leaflet to patient. Where the patient is incapacitated, ensure that relative/carer is given a leaflet and information about the assessment for bedrails is provided.		
			Ensure all actions, including discussions with relative/ carer are documented.		
			Refer to the Safe Use of Bedrails in Adult In-Patient Settings Guideline for further guidance on the management of bedrails.		
			Re-assess the need for bedrail use at least weekly or as the patient's condition indicates and document on the risk assessment chart.		
			This care plan has been discussed and agreed with the patient as appropriate.		

Moving & Handling
Patient Risk Assessment

Write or attach label

HCR No:.....

CHI No:.....

Surname:.....

Forename:..... Sex:.....

Address:.....

.....

Date of Birth.....

All Patients:

Sliding aids **must** be used bed to trolley/bed unless the patient transfers independently
A hoist **must** be used if assistance is required from the floor
A hoist **must** be used for bathing unless independently mobile
Hoists are for lifting patients and must not be used for transport between rooms

Special Alerts: Date:						
Overweight / Obese (BMI definition)						
Very tall (>185cm in height)						
Restricted use of limbs						
Poor standing ability						
Sedation or lethargy						
Irrational behaviour / confusion						
Unable to co-operate						
Acute pain						

Assessment of Risk:

Low Risk: Independently mobile / supervision only required. Aids required should be specified in care plan

Moderate Risk: Requires physical assistance from one or more handlers. Is able to stand or partially bear weight and has no more than one special alert.

High Risk: (a) Is unable to bear weight and requires assistance.
(b) 2 or more special alerts present and requires assistance.

Aids, equipment and a minimum of 2 handlers recommended to move a patient.

Specify Level of Risk

Date:						
LOW RISK						
MODERATE RISK						
HIGH RISK						
Assessor's Initials						

If a hoist or standing aid is required please specify:

Sling type:		Size:		Manufacturer:	

Additional Comments:

_____

_____

_____

Risk Assessment

MOVING AND HANDLING CARE PLAN

Date:	24/8					
1. Moving in bed:						
a) Independent	a) ✓					
b) Handlers and sliding sheets required to move in bed - specify number of handlers in grid	b)					
c) Specify any additional equipment required in grid	c)					
2. Sitting to Standing:						
a) Independent	a) ✓					
b) Requires assistance from sit/stand to sit? Specify number of handlers in grid	b)					
c) Also requires aids. Specify equipment in grid	c)					
4. Transfers: (chair / wheelchair / commode / toilet / bed)						
a) Independent or with minimal supervision	a) ✓					
b) Assistance required from handlers specify number of handlers in grid.	b)					
c) Equipment required - specify equipment in grid	c)					
4. Adjusting Clothing						
a) Independent or minimal supervision	a) ✓					
b) Can use support/grab rails while assistance is given with clothing	b)					
c) Requires support from Handler(s) while another assists with clothing	c)					
d) Requires equipment, specify equipment in grid	d)					
5. Repositioning in chair / wheelchair:						
a) Independent or minimal supervision	a) ✓					
b) Assistance from handler(s), specify number in grid	b)					
c) Specify other aids or equipment required in grid	c)					
6. Mobilising:	Documented in Mobility Care Plan					
Assessors initials	AW					

If it is decided to stand, transfer or mobilise a patient requiring assistance of more than 2 handlers, without equipment, a detailed assessment outlining the decision making process must be documented in the mobility careplan.

RISK ASSESSMENTS

Mobilising - Care Plan

Write or attach label
HCR No:.....
CHI No:.....
Surname:.....
Forename:..... Sex:.....
Address:.....
.....
Date of Birth.....

Patient Problem/Need
Patient has restricted mobility/mobility is deteriorating due to.....
Goal
To optimise ability to mobilise safely and maintain independence as much as possible

Date	Time	Initial	Planned Nursing Interventions	Discontinued Date/Time	Initial
			Refer to moving and handling risk assessment tool and plan care accordingly.		
			Mobilise/transfer with assistance of one/two handlers.		
			Mobilise/transfer with supervision.		
			Mobilising with appropriate handling equipment and/or aids, please state:-		
			• Walking stick one/two		
			• Tripod/quad		
			• Zimmer frame/rolator		
			• Wheel chair		
			• Hoist aid (specify equipment used)		
			• Other (please specify)		
			Refer to physiotherapist and action specialist requirements.		
			This care plan has been discussed and agreed with the patient and/or carer/relative as appropriate.		

Referrals to Multidisciplinary Team During Admission

Date	Initials of staff making referral	Referrals	Contact Number/ Page	Date Reviewed	Initials
		Alcohol Liaison Team			
		Community Learning Disability Team			
		Community Mental Health Team			
		Community Mental Health Team Elderly			
		Community Nurse			
		Community Psychiatric Liaison Team			
		Community Psychiatric Liaison Team Elderly			
		Dental			
		Diabetic Team			
		Dietitian			
		Discharge Co-ordinator			
		Fresh Air-shire			
		Home Care Organiser			
		Intermediate Care and Enablement Services			
		Occupational Therapist			
		Palliative Care Team			
		Pain Team			
		Pharmacist			
		Physiotherapist			
		Podiatrist			
		Psychiatric Liaison Team			
		Speech and Language Therapist			
		Social Worker			
		Specialist Nurse			
		Tissue Viability			
		Other - please specify			

Care Plans and Monitoring Charts Evaluation

HC XH-16-048324-1
CH DOB: 14/06/1965 Male
Sur GALLOWAY Stephen
For 28 REDBURN PLACE, IRVINE
Ad KA12 9BH
.....
Dat 1406650854

Code	Care Plan / Monitoring Chart	Code	Additional specific care plans / monitoring Charts
A	Admitted as an emergency	1	
B	Breathing	2	
C	Catheter	3	
D	Cleansing and dressing	4	
E	Elimination	5	
F	Falls	6	
G	Bedrails	7	
H	Mobilising	8	
J	Communication	9	
K	Pre - operative	10	
L	Post - operative	11	
M	Wound Management	12	
N	Pressure area care/SSKIN / PPURA	13	
O	Oral Hygiene	14	
P	Pain Management	15	
R	MUST - Eating and Drinking	16	
S	Emotional Wellbeing/Anxiety	17	
T	MRSA	18	
V	MEWS	19	
W	Fluid Balance Chart	20	
X	PVC Chart	21	
Y	Investigations		

Care Plans

Initial Presentation and Plan

XH-16-048324-1
H(DOB: 14/06/1965 Male
Cl GALLOWAY Stephen
St 28 REDBURN PLACE, IRVINE
F(KA12 9BH
A
Date of Birth

Ward CAO

Date & Time	Immediate presenting history (inc GP, ED or clinic)	Initials
24/8/16	1645 Patient admitted with 3 day history of chest pain. (L) arm tingling & numbness. MEWS 0. on admission awaiting medical review	

Ward Round Instructions / Goals of Care

Write or attach label

HCR No:
CHI No:
Surname: Galloway
Forename: Stephe Sex:
Address:

Date of Birth:

Ward

Date & Time	Ward Round Instructions	CLD	EDD	Initials
	convived. may well need OP MRI neck + neuro input			
	④ ETT + cardio f/u.			
	⑤ Vitamin B_{12} / folate / ferritin / bone profile + neuropathy screen.			
	⑥ Watch for alcohol withdrawal - diazepam withdrawal protocol.			
	⑦ one 3 sample oral antibiotics if indicated			DMG
25/5/16 10am	Reviewed by Dr Manuel.			
	? Cervical nerve root compression or brachial plexus traction			
	Plan. D/C			
	OP MRI			
	c/w amitriptyline 10mg Nocte			
	OP E11			AJ

Ward Round Instructions

Ward _____

Date & Time	Ward Round Instructions	CLD	EDD	Initials

Write or attach label

HCR No:.....

CHI No:.....

Surname:.....

Forename:..... Sex:.....

Address:.....

.....

Date of Birth.....

Ward_____

Date & Time	Ward Round Instructions	CLD	EDD	Initials

Ward _____

Date & Time	Ward Round Instructions	CLD	EDD	Initials

HCF CHI: 1406650854
CHI Galloway, Stephen
Surr 28 Redburn Place
Fore Irvine
Add KA12 9BH
..... 14/06/1965
Date Dr A Sharma
MRN: XHI468158

Ward _____

Date & Time	Care plan Code	Nursing Evaluation	Initials
25.8.16	✓	MEWS 0.	
0840	D	Not scoring on CIWA at present.	
	M	Ind mobile. Been out for cigarettes - smoking disclaimer signed.	
	S	Settled night so far.	LS
0705	A	Offering no complaints overnight - No evidence of alcohol withdrawal. Slept for spells.	
	V	observations as charted.	PE
1055	A	Parent for discharge haematology. To go to discharge lounge. Discharge prescription getting done just now ———	DVE
1125	A	Parent given discharge medication by pharmacy, ambulance arranged, doesn't require discharge lounge now, no cannula in situ ———	DVE
		For further investigations of numbness (L) arm etc. outpatient MRI, nerve conduction studies. Appointment ETT ———	DVE

O_2	A	A	Air	Air	A		
Saturation	98	97	97	98	97	95	

Temperature (°C)	0	0	0	0	0	0	
BP (Systolic)	0	0	0	0	0	0	
Heart Rate	0	0	0	0	0	0	
Respiratory Rate	0	0	0	0	0	0	
S_pO_2	0	0	0	0	0	0	
Urine Output	0	0	0	0	0	0	
GNS	0	0	0	0	0	0	

MEWS SCORE for EACH of the INDIVIDUAL OBSERV NS

MEWS SCORE - TOTALS

Record the total MEWS scores for each set of observations this way

3							
2							
1							
0							

Sedation Score			0				
Pain Score (On Movement)			0				
Nausea Score			0				

C Eyes Open	Spontaneously	4
	To speech	3
	To pain	2
	None	1
M Best Verbal Response	Orientated	5
	Confused	4
	Inapprop. words	3
	Incomp. sounds	2
	None	1
S C Best Motor Response	Obeys commands	6
	Localise pain	5
	Withdrawal to pain	4
	Abnormal flexion to pain	3
	Extension to pain	2
	None	1
	GCS TOTAL	

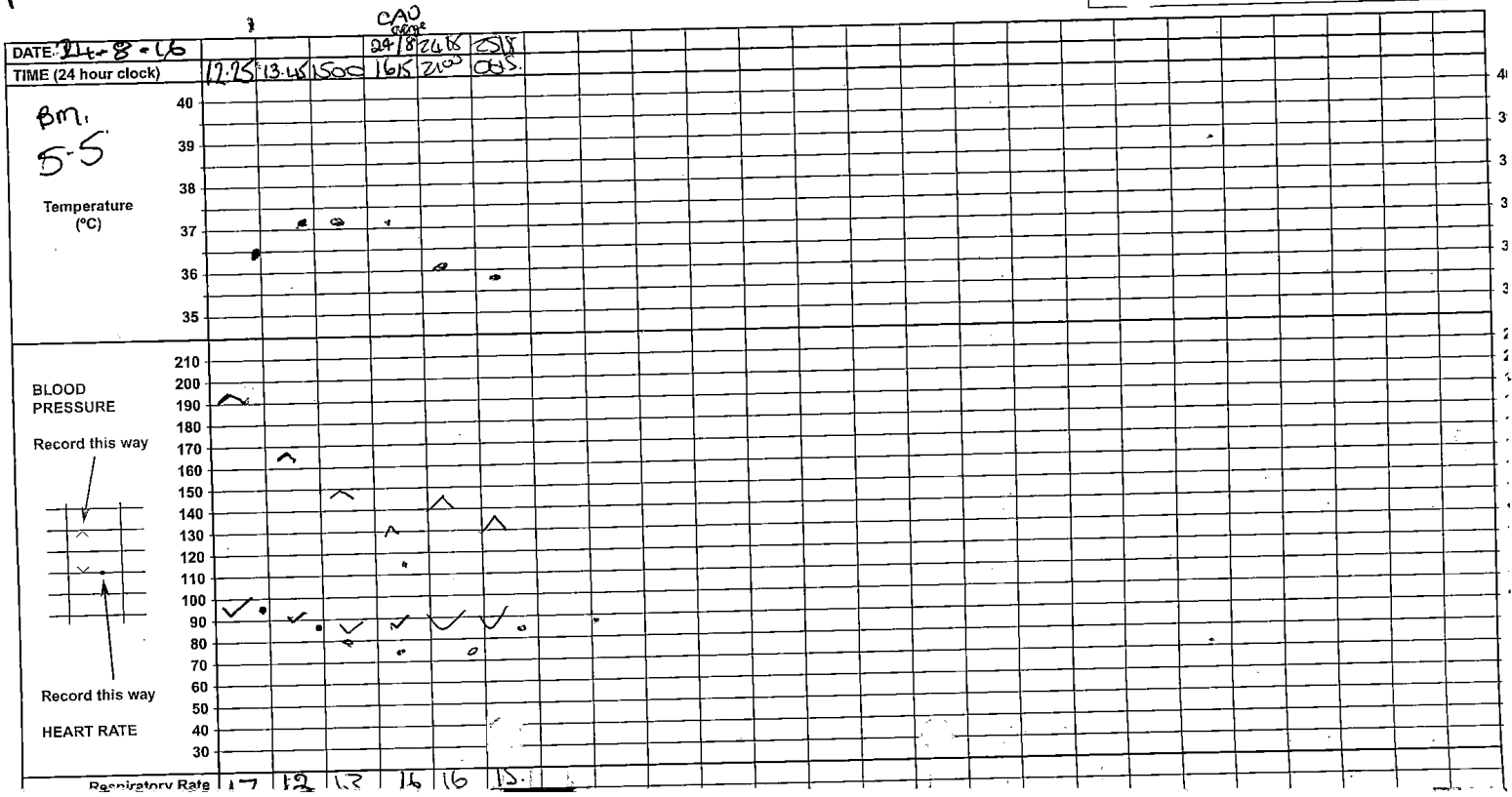
PUPILS	R	Size
		Reaction
	L	Size
		Reaction
LIMB MOVEMENTS ARMS		Normal power
		Mild weakness
		Severe weakness
		Spastic flexion
		Extension
		No response
LEGS		Normal power
		Mild weakness
		Severe weakness
		Extension
		No response

STA4202

NHS Ayrshire & Arran

MEWS CHART
(with Neuro - Observations)

XH-16-048324-1
Male
DOB: 14/06/1965
GALLOWAY Stephen
28 REDBURN PLACE, IRVINE
KA12 9BH



Please record **ALL** food and drink taken by patient **INCLUDING SUPPLEMENTS**

DATE	TIME	FOOD / DRINK OFFERED	PORTION SIZE OFFERED e.g. Spoonful or Weight (ml/g)	AMOUNT EATEN e.g. 1/4, 1/2 or all
	Breakfast			
	Mid Morning			
	Lunch			
	Mid Afternoon			
	Evening Meal			
	Supper			
	Breakfast			
	Mid Morning			
	Lunch			
	Mid Afternoon			
	Evening Meal			
	Supper			

NHS Ayrshire & Arran

3 DAY FOOD RECORD CHART

HCF CHI: 1406650854
CHI Galloway, Stephen
Surr 28 Redburn Place
Fore Irvine
Addi KA12 9BH
..... 14/06/1965
Dr A Sharma
MRN: XHI468158
Date of Birth: .....

Please record **ALL** food and drink taken by patient **INCLUDING SUPPLEMENTS.**

Please turn over for **Day 2 & Day 3**

DATE	TIME	FOOD / DRINK OFFERED	PORTION SIZE OFFERED e.g. Spoonful or Weight (ml/g)	AMOUNT EATEN e.g. 1/4, 1/2 or all
Examples	Breakfast	Tea / Milk / Sugar	180ml / 20ml / 1tsp	ALL
31.03.05	Breakfast	Wholemeal Bread / butter	1 Slice / 1 Pat	1/2
31.03.05	Lunch	Mince	As Served	3 Dessertspoons
31.03.05	Lunch	Potato Mashed	2 Scoops	1 Scoop
31.03.05	Mid - Afternoon	Fresubin Energy Drink	200mls	ALL
	Breakfast	2 x White toast	As Served 2nd	ALL
		Coffee	200ml	ALL
	Mid Morning			
	Lunch			
	Mid Afternoon			
	Evening Meal			
	Supper			

APPROXIMATE MEASURES

Klix cup 200ml
Standard teacup 150mls
Mug 200-300mls
Beaker 200mls
White polystyrene cup 180mls (Build up)
Glass tumbler (full) 180mls

1 Teaspoonful 5ml
1 Dessertspoonful 10ml

P.T.O

NHS Ayrshire & Arran

COMFORT ROUND (Independe

Must Do for me: Ask the patient if there is anything they want specifically done today

Date: _____

Date: _____

Write or attach label

HCR No:

CHI No:

Surname: Galloway

Forename: Helen Sex:

Address:

Date of Birth:

✓ when care is offered / given R – refused V – variance O – off ward

Date Year:	24/8/16	24/8	25/8	25/8	25/8/16	25/8																							
Time – record using 24-hour clock	2200	2330	0530	0630	0810	0930																							
Frequency of care round: 2hrly	2	2			2																								
Assess pain & ensure patient is comfortable (Pain present? Commence pain chart and action)	✓	✓			✓	✓																							
Encourage/support oral diet & fluids where appropriate	✓	✓			✓	✓																							
Offer assistance to visit toilet/any other continence needs																													
Offer assistance with hand washing																													
Assist with personal hygiene as required: **BB**-bedbath **IB**-immersion bath **BW**-basin wash **SH**-shower																													
Offer assistance with oral care			✓	✓	✓																								
Call buzzer in reach & working	✓	✓	✓	✓	✓	✓																							
Appropriate footwear available & in use	✓	✓			✓	✓																							
If glasses & hearing aid worn, they are available & in use	✓	✓			✓	✓																							
Provide assurance that you will return in a timescale	✓	✓	✓	✓	✓	✓																							
Patient is asleep			✓	✓																									
INITIALS	CJ	KS	CJ	KS		OH																							

PPURA - To be done daily. If No to any questions undertake Waterlow assessment and apply the SSKIN bundle if indicated

Mobility – patient is fully mobile without equipment/assistance	Yes ☐ No ☐	Yes ☐ No ☐
Continence- patient is fully continent	Yes ☐ No ☐	Yes ☐ No ☐
Nutrition- patient appears to be well nourished and able to eat and drink	Yes ☐ No ☐	Yes ☐ No ☐
Skin- skin is healthy and intact	Yes ☐ No ☐ INITIALS:	Yes ☐ No ☐ INITIALS:

CARE & COMFORT ROUND (Independent)

DATE/ TIME	ELEMENT NO.	EVALUATION	INITIALS

NHS Ayrshire & Arran

Revised Clinical Institute Withdrawal Assessment for Alcohol Scale (CIWA-Ar)

Write or attach label

HCR No: .....
CHI No: 1406650854
Surname: Galloway
Forename: Stephen Sex: .....
Address: .....
.....
Date of Birth .....

Score every One -Two Hours as per guideline.
Score 20 or above – administer 20mg Diazepam orally.
Score 15 to 19 – administer 10mg Diazepam orally.
Score 10 to 14 – repeat observations in One -Two hours.
Score <10 on 3 consecutive scores = Asymptomatic so discontinue.
If patient requires more than 120mg Diazepam in 24 hours then review alcohol withdrawal management plan and refer patient to FY2 and/or Alcohol Liaison Nurse.
Do not continue on discharge prescription.

Prescription	Dose	Instructions	Prescribed by
DIAZEPAM	10 or 20 mg as per score	Every One-Two hours as per modified CIWA-Ar scale	Date

FY2 review at	Instructions	Signature

Date	24/8	25/8									
Time	1855	0820									
Nausea & Vomiting	0	0									
Tremor	0	0									
Paroxysmal Sweats	0	0									
Anxiety	0	0									
Agitation	0	0									
Tactile Disturbance	0	0									
Auditory Disturbance	0	0									
Visual Disturbance	0	0									
Headache / Fullness	0	0									
Orientation / Clouding	0	0									
Total Score	0	0									
Dose Administered	nil	/									
Time Administered		/									
Given by	JMcC	JS									

Score Chart

Nausea & Vomiting
Ask "Do you feel sick to your stomach? Have you vomited?"
Observation.
0 No nausea and vomiting
1 Mild nausea with no vomiting
2
3
4 Intermittent nausea with dry heaves
5
6
7 Constant nausea, frequent dry heaves and vomiting

Tactile Disturbances
Ask "Have you any itching, pins and needles, any burning, any numbness or do you feel bugs crawling up and down your skin?"
Observation.
0 None
1 Very mild itching, pins & needles, burning, numbness
2 Mild itching, pins & needles, burning or numbness
3 Moderate itching, pins & needles, burning or numbness
4 Moderate severe hallucinations
5 Severe hallucinations
6 Extremely severe hallucinations
7 Continuous hallucinations

Tremor
Arms extended and fingers spread apart.
Observation
0 No tremor
1 Not visible, but can be felt fingertip to fingertip
2
3
4 Moderate, with patient's arms extended
5
6
7 Severe, even with arms not extended

Auditory Disturbance
Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing you? Are you hearing things you know are not there?"
Observation.
0 Not present
1 Very mild harshness or ability to frighten
2 Mild harshness or ability to frighten
3 Moderate harshness or ability to frighten
4 Moderate severe hallucinations
5 Severe hallucinations
6 Extremely severe hallucinations
7 Continuous hallucinations

Paroxysmal Sweats
Observation.
0 No sweat visible
1 Barely perceptible sweating, palms moist
2
3
4 Beads of sweat obvious on forehead
5
6
7 Drenching sweats

Visual Disturbances
Ask "Does light appear too bright? Is colour different? Does it hurt your eyes? Are you seeing anything that is disturbing you? Are you seeing things you know are not there?"
Observation.
0 Not present
1 Very mild sensitivity
2 Mild sensitivity
3 Moderate sensitivity
4 Moderate severe hallucinations
5 Severe hallucinations
6 Extremely severe hallucinations
7 Continuous hallucinations

Anxiety
Ask "Do you feel nervous?"
Observation.
0 No anxiety, at ease
1 Mildly anxious
2
3
4 Moderately anxious, or guarded, so anxiety is inferred
5
6
7 Equivalent to acute panic states as seen in severe delirium or acute schizophrenic reaction

Headache, Fullness in Head
Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate dizziness or light-headedness. Otherwise, rate severity
0 Not present
1 Very mild
2 Mild
3 Moderate
4 Moderately severe
5 Severe
6 Very severe
7 Extremely severe

Agitation
Observation.
0 Normal activity
1 Somewhat more than normal activity
2
3
4 Moderately fidgety and restless
5
6
7 Paces back and forth during most of the interview or constantly thrashes out

Orientation and Clouding of Sensorium
Ask "What day is it? Where are you? Who am I?"
0 Orientated and can do serial additions
1 Cannot do serial additions or is uncertain about date
2 Disorientated for date by no more than 2 calendar days
3 Disorientated for date by more than 2 calendar days
4 Disorientated for place and / or person

Vital Signs Monitoring

Date/Time										
BP										
Pulse										
Resp Rate										

Reference: ADTC 54a (1) Supersedes: DTC 34 (1) Date Written: July 2007 Date Approved by ADTC: 16th November 2007 Review Date: November 2010
Written by: NHS Ayrshire and Arran CIWAA-Ar short life working group

Ref: Sullivan J et al Assessment of Alcohol Withdrawal: the revised clinical institute withdrawal assessment for alcohol scale (CIWA –Ar). British Journal of Addiction 1989; 84: 1353-1357

NHS
Ayrshire
& Arran

SMOKE FREE GROUNDS POLICY

DISCLAIMER GUIDANCE

Please note as part of the nursing admission documentation all those who smoke should be referred to the Fresh Air-shire team (by placing a patient sticker onto a referral card and then into the black box) so that they can provide information about the smoke free grounds policy and help the patient to manage their smoking while in hospital

Stephen Galloway
28 Redburn Place

Irvine
Ayrshire
KA12 9BH

Smoke Free Grounds Policy

Patient Disclaimer

Hospital:	CROSSHOUSE
Ward/Station/Dept:	CAM orange.
Patient Name:	Stephen Galloway

I STEPHEN GALLOWAY (print name) have been provided with information regarding the management of smoking in hospital in compliance with the NHS Ayrshire & Arran Smoke Free Grounds Policy and I understand that I am not permitted to smoke anywhere on NHS A&A grounds.

I have read and understood this information. I have been advised against leaving the ward to smoke. I understand that there are risks associated with leaving the ward/department. In particular I understand that my decision will affect the medical attention I receive and that NHS Ayrshire & Arran cannot provide medical care and attention to me whilst I am absent from the ward/department. I therefore accept that the staff cannot be responsible for my care whilst I am absent from the ward and hospital grounds.

Patient Signature:	x [signature]	Witness Signature:	[signature]
Date:		Date:	2040 * 24/8/16
Time:		Time:	

PLEASE FILE THIS FORM IN NURSING NOTES ENSURING CIRCUMSTANCES ARE FULLY DOCUMENTED

HIGH RISK INFUSION THERAPY CHART

NHS AYRSHIRE & ARRAN

SHEET NUMBER: .....

PATIENT WEIGHT: .....

ALLERGIES: .....

GALLOWAY Stephen
28 REDBURN PLACE, IRVINE
KA12 9BH
DOB: 14/06/1965

Date of Birth .....

1 MEDICINE AND DILUTION DETAILS (to be completed by PRESCRIBER before start of therapy) Consult Pharmacy prior to prescribing additives

MEDICINE	Total Amount of Drug (mg)	Diluent	Total Volume (mls)	Drug Concentration (mg / ml)	Route of Administration	Prescriber's Signature
1 POTASSIUM CHLORIDE	40 mmol	Sodium Chloride 0.9%	500 mls	0.08 mmol/ml	IV	
Additive 1						
Additive 2						

2 DOSE AND FLOW RATE DETAILS (to be completed by PRESCRIBER)

	Date	Start Time	Dose or Range to be Administered (Dose / Weight / Time)	Required Flow Rate Setting or Range (mls / hour - mm / time)	If Range, Actual Flow Rate to be commenced (mls / hour - mm / time)	Prescriber's Signature
Initial rate	13/10		10 mmol/hour	125 mls/hour		
New rate						
New rate						
New rate						
New rate						
New rate						

3 PREPARATION / PRODUCT DETAILS (where a pre-prepared solution is available, the batch number should be recorded under the *Drug* section below)

	Date	Time	Prepared by	Checked by	Batch Number Drug(s)	Batch Number Diluent
Initial Preparation	13/10/15	0255	JA	GM	388133	23HOST6A
Replacement 1						

4 MONITORING AND DEVICE SELECTION (To be completed by Nurse / Prescriber before start of therapy)

Infusion Device Selected	Agilia
Serial / Equipment Numl	26660
Monitoring Requirements	1 Cardiac

2										2	
Replacement 3										3	
Replacement 4										4	

5 ADMINISTRATION CHECK (To be completed in full by Nursing Staff) — **HOURLY**

6 START / STOP / RATE CHANGE CHECK The reason for the alteration must always be recorded.

Date	Time Infusion Checked or Stopped	Total Volume Infused	Volume Remaining (Approximate)	Actual Rate Setting	Check by	Time Infusion Started / Restarted	Rate Setting	Started / Restarted by	Checked by	10 minute check	Reason for change in rate / stop. Comments
13/10	0327	0	500	125ml/hr	SM						
13/10	0540	278	222	125ml/hr	SM						
13/10	0645	127	373	125ml/hr	DE						

NHS Ayrshire & Arran

Preliminary Pressure Ulcer Risk Assessment

STATEMENTS

Mobility: Person is fully mobile without equipment/assistance
Continence: Person is fully continent
Nutrition: Person appears well nourished and able to eat and drink

Wi XH-15-004043-1
DOB: 14/06/1965
Si GALLOWAY Stephen
28 REDBURN PLACE, IRVINE
F KA12 9BH
C
L

Male

Record your answer on the grid below **Y** – Yes or **N** – No
If the answer is **Yes** to all statements reassess at least every 72 hours
If the answer is **No** to any statement undertake a full pressure ulcer risk assessment and consider any other relevant assessment

Date	Time	Mobility	Continence	Nutrition	Skin inspected - healthy	Skin integrity discussed with patient - healthy	Is Waterlow required?	Signature
21/1/15	19:35	Y	Y	Y	Intact	—	N	

NHS Ayrshire & Arran

MRSA SCREENING
CLINICAL RISK ASSESSMENT (CRA)

COMPLE XH-15-004043-1

ADMISSIONS (Ayr & Crosshouse Hospital Only)

ATTACH PATI	DOB: 14/06/1965 Male
Patient Name:	GALLOWAY Stephen 28 REDBURN PLACE, IRVINE KA12 9BH
CHI:	
Date of admissi	
Ward/Hospital:	

Completed by if not using admission booklet	
Name:	KMCAuley
Designation:	SN
Signature:	
Date / Time:	21/01/15 1930

FORM COMPLETED IN	
Pre-op	
Admitting Ward	✓

	Yes	No	Don't know
1. Has the patient had any **previous history of MRSA** colonisation or MRSA infection at any time in the past?		✓	
2. Is the patient currently **resident in a care home or institutional setting** (ie prison, homeless, hostel) or **transferred from another hospital?**		✓	
3. Does the patient **have a wound/ulcer or indwelling medical device** which was present before admission to this hospital?		✓	

OUTCOME OF CRA

Any of the above three questions answered 'yes'	▪ Screen nose and perineum (& wound or device where applicable) ▪ Manage patient as if MRSA positive (isolate if possible) ▪ Complete next section of the CRA
All three of the above questions 'no' or 'don't know'	▪ Patient is likely to be at low risk of MRSA and can be managed as normal in accordance with the Infection Control Policy. Do not complete the remainder of the form.
Direct admission to 4 high risk specialties (renal, orthopaedics, vascular / cardiothoracic, intensive care)	▪ Complete CRA and take a screen from nose and perineum (& wound or device where applicable) regardless of the outcome of answering the 3 questions above.

SCREENING ACTIONS ('YES' TO ANY CRA QUESTION & 4 HIGH RISK SPECIALTIES)

	Nose	Perineum	Wound	Device	Other
MRSA screening swabs taken **Tick all applicable (inc dates)**					

ISOLATION ACTIONS ('YES' TO ANY CRA QUESTION) (See definitions in footer)

	Patient isolated in a single room	Patient cohorted, with other high risk patients, dedicated nursing	Patient cohorted, with no dedicated nursing staff	Patient separated
Detail of action completed **Tick all applicable (inc dates)** *Particularly if unable to isolate – please state reasons				

LABORATORY RESULTS

Date results received	Result of swab (positive or negative)	Name (PRINT)

**HPS ISOLATION DEFINITIONS

Isolated: Patient is placed in a single room with hand washing facilities, ideally with ensuite toilet and shower where available. Isolation should be undertaken according to the HPS Infection Control Contact Precautions Policy

Cohorting: Patient is placed in a room and cared for by dedicated nursing staff along with other patients who are MRSA screen positive. Cohorting should be undertaken according to the HPS Infection Control Contact Precautions Policy.

Separated: Patients who are MRSA screen positive are housed within the same room as patients who are not MRSA positive but are separately by at least three feet from any adjacent persons by use of closed bed curtains. This is considered to be a step down from full cohorting. These patients do not have separate nursing staff. Separation should be undertaken according to the HPS Infection Control Contact Precautions Policy

http://www.hps.scot.nhs.uk/haiic/ic/standardinfectioncontrolprecautions-sicps.aspx

NHS Ayrshire & Arran

XH-15-004043-1
DOB: 14/06/1965 Male
GALLOWAY Stephen
28 REDBURN PLACE, IRVINE
KA12 9BH
1406650854

Bedrails Risk Assessment

Date of admission: 21/01/15

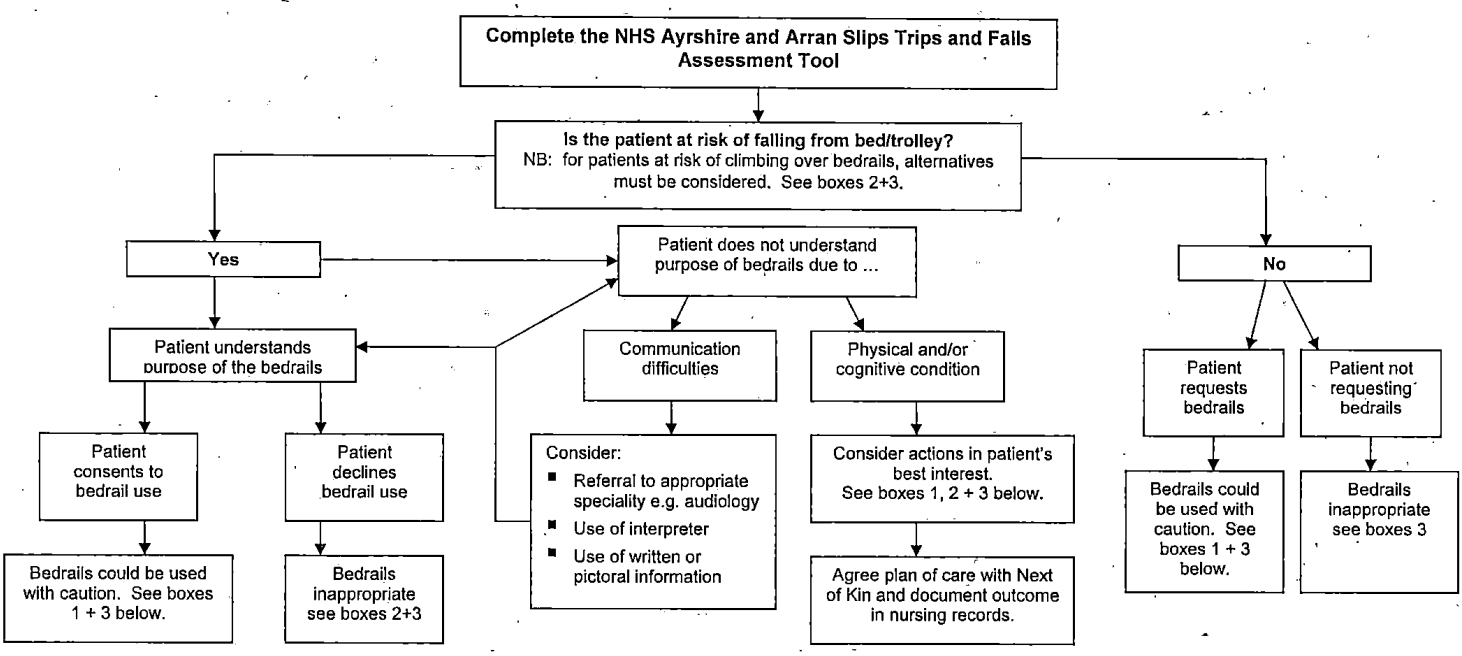
Please assess **ALL** patients on admission to your ward /departments

- Each statement must be answered – Circle answer
- Complete Risk Assessment in conjunction with Bedrails Algorithm overleaf
- Refer to Guidelines – Safe Use of Bedrails in In-patient Settings & Falls Management for in-patients

Re Assessment Occurs:

- Weekly
- When the patient's condition changes (i.e. patient falls/post surgery/change in medication/cognitive state changes.)
- **Ensure clear identification of change in use of bedrails**

Risk Factors	Ward: CCU Date: 21/1/15 Time: 1030	Ward: Date: Time:	Ward: Date: Time:	Ward: Date: Time:
1. Is the patient at risk of **falling** from bed?	YES / NO	YES / NO	YES / NO	YES / NO
2. Is the patient at risk of **intentionally** climbing over bedrails?	YES / NO	YES / NO	YES / NO	YES / NO
3. Is the patient at risk of **unintentionally** falling from the bed / trolley?	YES / NO	YES / NO	YES / NO	YES / NO
4. Does the patient **understand** the purpose of the bedrails? Consider communication difficulties and physical / cognitive condition.	YES /NO/NA	YES/NO/NA	YES/NO/NA	YES/NO/NA
5. Does the patient **consent** to the use of bedrails?	YES/NO/NA	YES/NO/NA	YES/NO/NA	YES/NO/NA
Has the Bedrails Algorithm been followed?	Yes ☐ ✓ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
According to the Bedrails Algorithm are bedrails required / appropriate?	Yes ☐ No ☐ ✓	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
If 'Yes', complete a bedrails care plan. **If 'No', state reason why bedrails are not required:** patient independent No Risk				
Signature and Designation	KM SN			



1. If bedrails are used consider:

- Risk of entrapment and harm to limbs
- Risk of patient climbing over the top
- The psychological effect of their use on the patient
- Ensure bed returned to lowest height after care delivery
- Use of the Dynamic mattress increases the height of the bed

2. Alternatives to bed rails

- Use of variable height bed
- Additional mattress/crash mat beside bed
- Close observation of patient
- Ensure bed returned to lowest height after care delivery
- Ensuring patient needs anticipated e.g. drinks are accessible, regular toileting, call bell to hand etc
- Nursing patient on mattress on the floor should be a last resort and safety checks should be made for hot pipes, electric sockets etc. Manual handling risk assessment for staff must be undertaken.

3. Remember to document in nursing records:

- Date and time assessment made
- Rationale for decision made in care plan
- Actions taken, including discussion with Next of Kin
- Care planning

Assessment should be made:

- On admission
- If patient's condition changes
- Weekly

XH-15-004043-1
DOB: 14/06/1965 Male
GALLOWAY Stephen
28 REDBURN PLACE, IRVINE
KA12 9BH

1406650854

Ward CDU
Date 21/1/15
Time 2000

NHS Ayrshire & Arran

Smoking disclaimer

Section one - Patient signature

I have been provided with information regarding the smoking ban in NHS Ayrshire & Arran wards and departments. This follows the introduction of the Smoking, Health and Social Care (Scotland) Act 2005.

I have been advised against leaving the ward to smoke and understand the risks associated with doing so. I, therefore, absolve staff of responsibility for my care whilst I am absent from the ward.

Signature: _____

Witness name: Soconna

Witness signature: Soconna

Section two - Escort signature

To be completed by adult escort for patients dependent on assistance to leave the ward to smoke.

I _____ have been made aware of the implications of the Smoking, Health and Social Care (Scotland) Act 2005 and take responsibility for above patient while he or she is absent from the ward to smoke. I understand that staff cannot provide care while the patient is not present on the ward.

Signature: _____

Witness name: _____

Witness signature: _____

Please file this form in nursing notes ensuring circumstances are fully documented.

61 447

MEWS SCORE for EACH of the INDIVIDUAL OBSERVATIONS																									
Temperature (°C)	0	0	0	0																					
BP (Systolic)	0	0	0	0																					
Heart Rate	0	0	0	0																					
Respiratory Rate	0	0	0	0																					
SpO_2	0	0	0	0																					
Urine Output	0	0	0	0																					
CNS	0	0	0	0																					
MEWS SCORE - TOTALS																									
Record the total MEWS scores for each set of observations this way	6																								
	5																								
	4																								
	3																								
	2																								
	1																								
	0																								

Sedation Score	0	0	0	0																					
Pain Score (On Movement)	0	0	0	0																					
Nausea Score	0	0	0	0																					

C Eyes Open	Spontaneously	4																							
	To speech	3																							
	To pain	2																							
	None	1																							
A Best Verbal Response	Orientated	5																							
	Confused	4																							
	Inaprop. words	3																							
	Incomp. sounds	2																							
S	None	1																							
C Best Motor Response	Obeys commands	6																							
	Localise pain	5																							
	Withdrawl to pain	4																							
	Abnormal flexion to pain	3																							
	Extension to pain	2																							
M	None	1																							
GCS TOTAL																									
PUPILS	R	Size																							
		Reaction																							
	L	Size																							
		Reaction																							
LIMB MOVEMENTS	ARMS	Normal power																							
		Mild weakness																							
		Severe weakness																							
		Spastic flexion																							
		Extension																							
		No response																							
	LEGS	Normal power																							
		Mild weakness																							
		Severe weakness																							
		Extension																							
		No response																							

PUPIL SCALE (mm)

1 2 3 4 5 6 7 8

Initials	SH	ICM	SO	NKM																					

STA4202

NHS Ayrshire & Arran

MEWS CHART

(with Neuro - Observations)

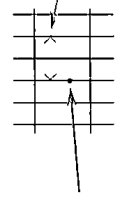
XH-15-004043-1
DOB: 14/06/1965 Male
GALLOWAY Stephen
28 REDBURN PLACE, IRVINE
KA12 9BH

DATE	21-04-15	21/4/15	21/4/15	21/4/15	22/4/15
TIME (24 hour clock)	17:50	19:20	21:40	00:30	

Temperature (°C): 40, 39, 38, 37, 36, 35

BLOOD PRESSURE: 210, 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40, 30

Record this way



Record this way

HEART RATE

Respiratory Rate	A7	17 A	17 A	17 RA
O_2				

Ayrshire & Arran
ACUTE HOSPITALS NHS TRUST

Patient Profile

WRITE, IMPRINT OR ATTACH LABEL

Surname _____ Hosp. No. _____
Forenames _____ Sex _____
Address _____ DoB _____
_____
Ward or Dept. _____

Date of Admission 12/5/12 Time 3.30 Pm
Type of Admission Emergency / ~~Elective~~
From where A&E
Age 86 Religion Ch of Scot.
Marital Status S.

SUMMARY OF PRESENTING CONDITION

LACERATION INSIDE OF (R) 4TH METATARSAL.

Next of Kin
Aware of Admission YES ☑ NO ☐
Name GINA FRAZER
Relationship NEIGHBOUR
Address
INSURE

Contact No. 07960 543966 Neb.
Alterntive Next of Kin Name
Relationship
Address

Contact No

GP Consultant

PREVIOUS HEALTH PROBLEMS

CHILDhood ASTHMA.
STOMAC ULCER

MEDICATION USED AT HOME

DRUG	DOSAGE
NIL	

ALLERGIES
K N A.

Stored in ward YES ☐ No ☐ Date Sign
Returned to patient ☐ Relative ☐

RECORD OF INVESTIGATIONS PROCEDURES AND SURGERY

Date	Procedure/Surgery	Patient aware of result

ADMISSION ASSESSMENT

Home circumstances

Living alone YES ☑ NO ☐ identfy carer(s)

Type of house

Stairs at entrance YES ☐ NO ☐ How many?

Toilet upstairs YES ☐ NO ☐

Bedroom upstairs YES ☐ NO ☐

COMMUNITY SERVICES

Home help	YES ☐	NO ☐	District Nurse	YES ☐	NO ☐
Meals on Wheels	YES ☐	NO ☐	Day Hospital	YES ☐	NO ☐
Sheltered house	YES ☐	NO ☐	Nursing Home	YES ☐	NO ☐
Visited by Specialist Nurse		YES ☐	NO ☐		

Which services informed of admission

DISCHARGE

Will personal transport be available for discharge YES ☐ NO ☐

Predicted discharge Complicated ☐ Uncomplicated ☑

PATIENTS PROPERTY

Property retained by patient:

I understand articles/valuables retained by me are my own responsibility.

Signature of patient or next of kin Date:

Property handed over for safe keeping:

Date taken to safe: Cash and valuables Ref. No.: Date returned:

OBSERVATION ON ADMISSION

Temperature	Pulse	BP	Respiration	O2 Saturation	Colour	LMP	BHCG	Glucostix
36.	100	150/88	20	96	Good			

URINALYSIS Midstream Urine sent for C+S YES ☐ NO ☐ Date

Methicillen resistant staphyloccus aureus YES ☐ NO ☐ Date Result

Print Name	IN	Grade	Signature	Print Name	IN	Grade	Signature
Jean d'Arcy	JDA	S/N	Jean d'Arcy				

IN - Initials DES - Designation SN - Staff Nurse EN - Enrolled Nurse STN - Student Nurse

Ayrshire & Arran
ACUTE HOSPITALS NHS TRUST

Activities of Living Assessment on Admission

WRITE, IMPRINT OR ATTACH LABEL

Surname _____ Hosp. No. _____
Forenames _____ Sex _____
Address _____ DoB _____
_____
Ward or Dept. _____

MAINTAINING A SAFE ENVIRONMENT Orientated to time and place YES ☑ NO ☐ Skin intact YES ☐ NO ☐ Waterlow Assessment Score Wound YES ☐ NO ☐	PROBLEMS / NEEDS
BREATHING Smoker YES ☑ NO ☐ Number per day 20 A DAY	PROBLEMS / NEEDS
CONTROLLING BODY TEMP Apyrexial on admission YES ☑ NO ☐	PROBLEMS / NEEDS
EATING AND DRINKING Mouth Assessed YES ☐ NO ☑ Special Diet YES ☐ NO ☑ Type of Diet Refer to Dietitian YES ☐ NO ☑ Refer to speach Therapist YES ☐ NO ☑	PROBLEMS / NEEDS
MOBILISING Independent YES ☑ NO ☐ Refer to Moving and Handling Assessment Podiatry problems YES ☐ NO ☑	PROBLEMS / NEEDS
ELIMINATING Normal Bowel Activity Last Bowel Motion Incontinent Bladder ☐ Bowel ☐ Catheterised YES ☐ NO ☑ Stoma YES ☐ NO ☑	PROBLEMS / NEEDS

COMMUNICATING			PROBLEMS / NEEDS
Glasses	YES ☑	NO ☐	
Contact Lenses	YES ☐	NO ☑	
Hearing Aid	YES ☐	NO ☑	
Speech Difficulty	YES ☐	NO ☑	

PERSONAL CLEANSING AND DRESSING			PROBLEMS / NEEDS
Independent	YES ☑	NO ☐	
Assistance with			

WORKING AND RECREATION	PROBLEMS / NEEDS
Occupation	
Hobbies	
Alcohol intake BOTTLE OF VODKA A DAY	

SLEEPING			PROBLEMS / NEEDS
Pattern Good.			
Night sedation	YES ☐	NO ☐	
Sleeps with	pillows		

EXPRESSING SEXUALITY			PROBLEMS / NEEDS
Possible altered body image	YES ☐	NO ☐	
Wears dentures	Top ☐		
	Bottom ☐		
	Partial ☐		
	Crowns ☐		
Any other prosthesis			

DYING / EMOTIONAL PROBLEMS / NEEDS	PROBLEMS / NEEDS
General mood on admission	
Specific worries re-admission	
Specific history of depression	

Signature of Admitting Nurse _____ Date _____

Sign Named Nurse _____ from _____ to _____

Sign Named Nurse _____ from _____ to _____

Sign Named Nurse _____ from _____ to _____

MEDICINES TO BE GIVEN ONCE (BLOCK CAPITALS)

PHARM.	TO BE GIVEN		APPROVED NAME OF MEDICINE	DOSE	ROUTE (see key)	DOCTOR'S SIGNATURE	GIVEN BY	TIME GIVEN
	DATE	TIME						

SHEET No. .....

MEDICINE PRESCRIPTION SHEET

KEY: **O** ORAL; **IM** INTRAMUSCULAR; **IV** INTRAVENOUS; **SC** SUBCUTANEOUS; **SL** SUBLINGUAL; **ID** INTRADERMAL; **INH** INHALATION; **NEB** NEBULISED; **PR** PER RECTUM; **PV** PER VAGINA; **IT** INTRATHECAL

Write, Imprint or attach label

Surname Causeway HCR No. .....

Forenames Steven Sex M

D.O.B. 14/6/65

Address .....

Ward/Dept. 2A

KNOWN SENSITIVITY Nil

1.	2.

SUSPECTED ADVERSE REACTION

MEDICINE	ADVERSE EFFECT
1.	
2.	

MEDICINES TO BE GIVEN REGULARLY (BLOCK CAPITALS)

PHARM.	Date Commenced	APPROVED NAME OF MEDICINE	DOSE	TIMES OF ADMINISTRATION									OTHER		ROUTE (see key)	OTHER INSTRUCTIONS	DOCTOR'S SIGNATURE	DISCONTINUED	
				6 am	8 am	10 am	12 md	2 pm	6 pm	8 pm	10 pm	12 mn						DATE	INITIAL
DH	A 12/5/12	PARACETAMOL	1g		4	6	PRN	max	4g/day						O				
	B																		
	C																		
	D																		
	E																		
	F																		
	G																		
	H																		
	I																		
	J																		
	K																		
	L																		
	M																		
	N																		
	O																		
	P																		
	R																		
	S																		
	T																		
	V																		

STA 0235

SHEET No .....

MEDICINE RECORDING SHEET

Name .....

Age .....

Consultant .....

Hospital .....

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record A

If patient absent record A If medicine not available record A

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
12/4/02								Codeine		
	Init.									
13/4/02		A			(A)					A 3PM
	Init.	NT			TC.					
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

SHEET No .....

MEDICINE RECORDING SHEET

Name .....

Age .....

Consultant .....

Hospital .....

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record A

If patient absent record A If medicine not available record A

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

STA0849

AYRSHIRE AND ARRAN ACUTE HOSPITALS NHS TRUST

Crosshouse Hospital Discharge

95461

G.P.

Patient Details:

Surname:
First Name:
Address:

DOB:
Unit No:
(or date of birth if no unit number)

Ward:
Consultant:

Date of Admission:
Date of Discharge:
(or date of death)
Clinic Appointment:

Services Arranged: ☐ Home help ___ times week ☐ Meals on wheels ☐ District Nurse ☐ Other
Discharged to: ☐ Home ☐ Stay with relatives ☐ Other hospital ☐ Nursing home ☐ Other ☐ Died

Discharge Diagnosis (if admitted due to an injury, include place of accident & site of injury)	If multiple Day Case admission, list dates of admission
1	
2	
5	

Operations / Procedures
1
2
3
4

Discharge Medication (7 days supply will be dispensed unless otherwise stated by doctor)

For Pharmacy use

Drug Name and formulation	**Dose**	**Frequency**	**Route**	**Duration** (cont/stop)	Quantity and strength	**Notes**
				pharmacy date	dispensed by	checked by

Additional Information (e.g. awaiting histology or other results, patients progress)

A finished consultant episode letter will follow.

Signature _____

PRINT NAME _____ Date / 20

N.B. DISCHARGE MEDICATION IS FOR INFORMATION ONLY. FAXED COPY HAS NOT BEEN CHECKED BY DOCTOR. ON RECEIPT OF HARD COPY, FAXED COPY CAN BE DESTROYED.

Ward Clerkess : 14/5 / Dictated : _____ / Typed : _____ / Signed : _____ / Mailed : _____

Surname GALLOWAY Hosp. No. 468158

Forenames Sex M

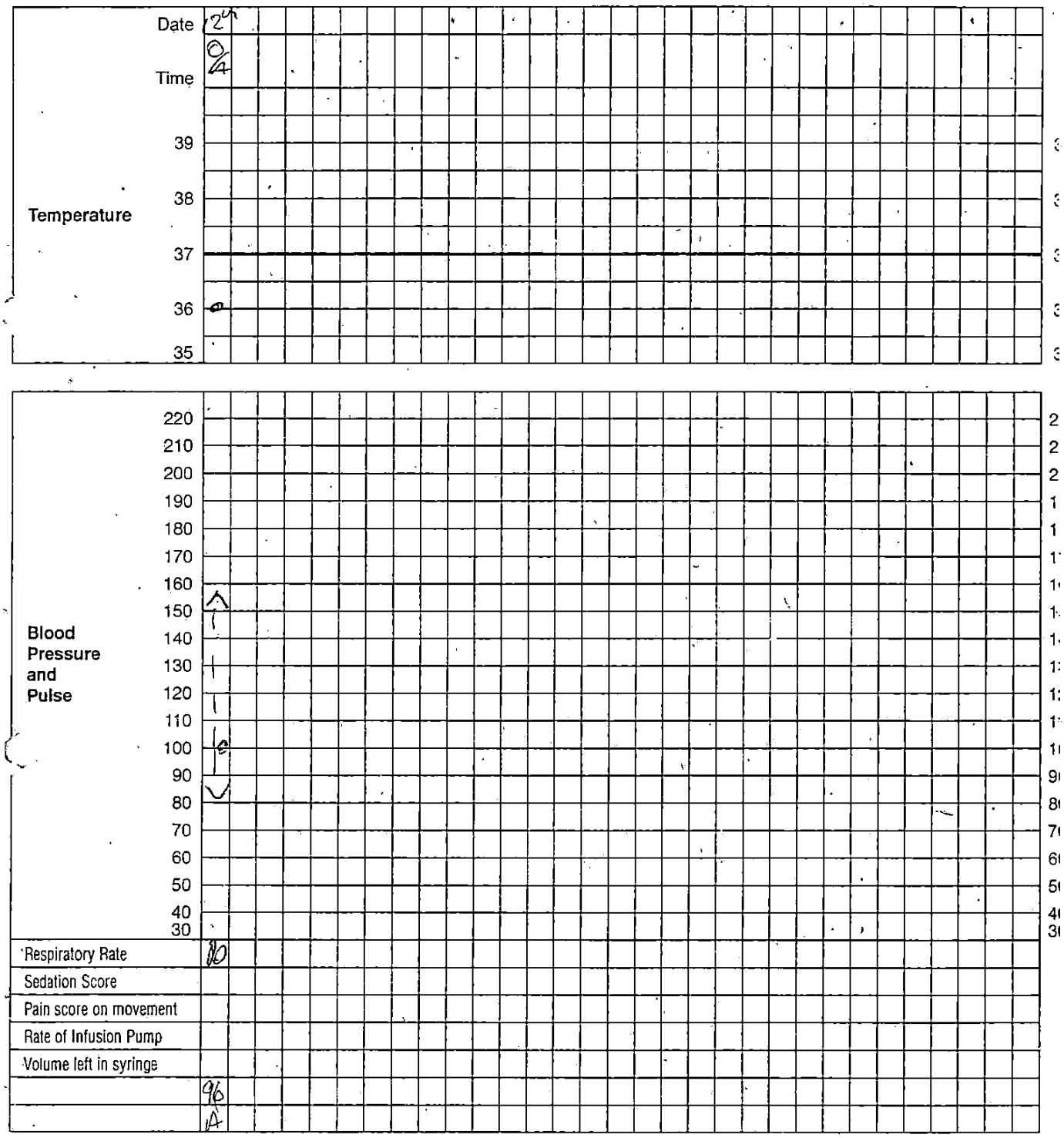
D.O.B.

Address

Ward/Dept. 2A

T.P.R., B.P. & Pain Chart

Commencement date: 12/5/12 Ward: 2A Named Nurse: Consultant: MR THET.



Pain Score

0 = No pain at rest; No pain on movement.
1 = No pain at rest; Slight pain on movement.
2 = Intermittent pain at rest;Moderate pain on movement.
3 = Continuous pain at rest; Severe pain on movement.
S = Asleep, pain not assessed.

Sedation Score

0 = None (patient alert).
1 = Mild (occasionally drowsy, easy to rouse).
2 = Moderate (frequently drowsy, easy to rouse).
3 = Severe (somnolent, difficult to rouse).
S = Normal sleep, easily roused.

For analgesia advice call .....Bleep.....Phone .....

Surname ..... Hosp. No. .....

Forenames ..... Sex .....

..... D.O.B. .....

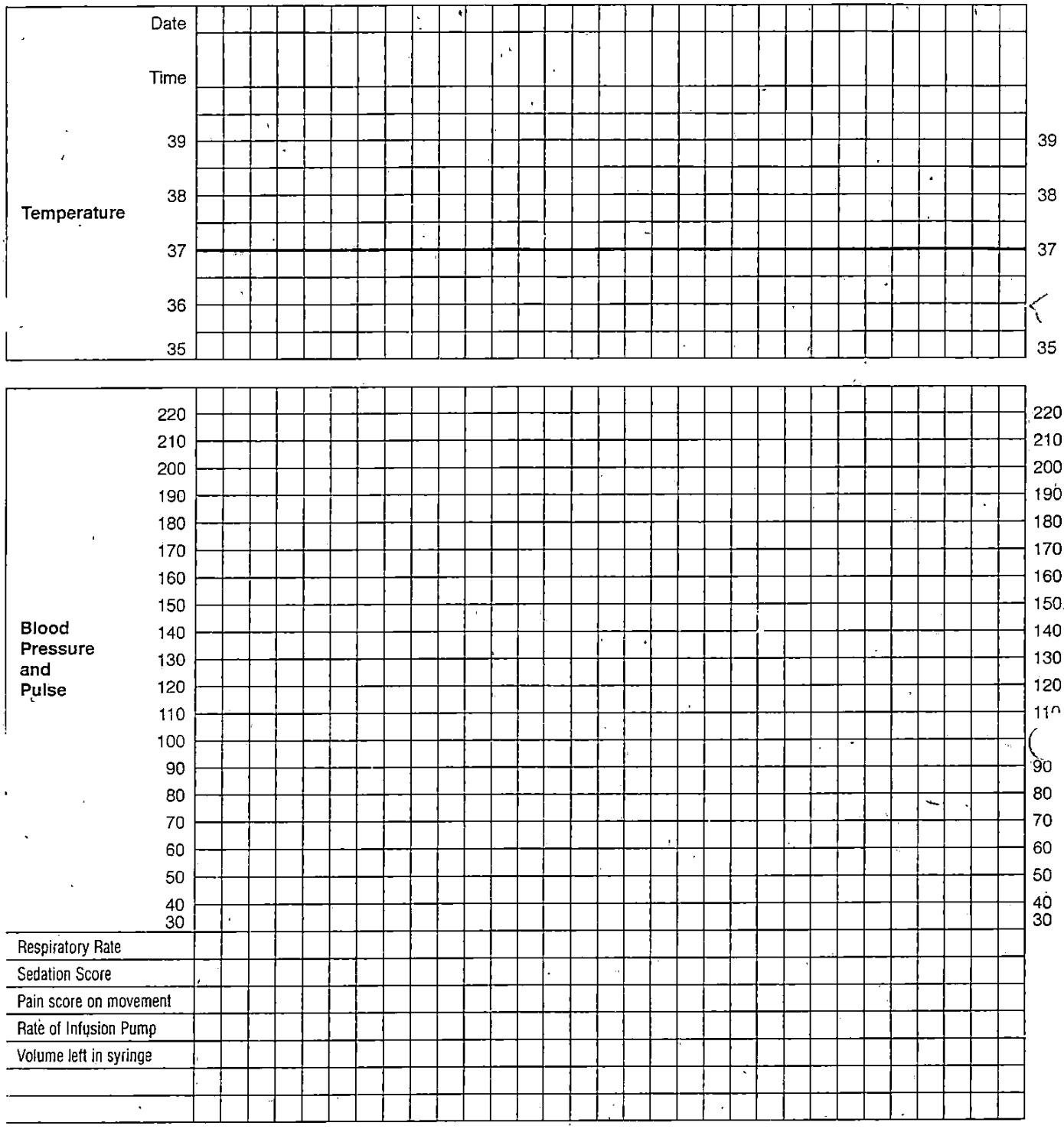
Address .....

.....

Ward/Dept. .....

T.P.R., B.P. & Pain Chart

Commencement date: / / Ward: Named Nurse: Consultant:



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2 = Moderate (frequently drowsy, easy to rouse).
3 = Severe (somnolent, difficult to rouse).
S = Normal sleep, easily roused.

For analgesia advice call .....Bleep.....Phone .....

AYRSHIRE AND ARRAN HEALTH BOARD

I hereby declare that I leave this Hospital contrary to the advice of the Doctor. I absolve the Ayrshire and Arran Health Board of any responsibility for my future Medical condition, as a result of my discharging myself on this date, contrary to Medical advice.

Date 21/7/07 Signature

Witness S/N

Witness MBChB

Ayrshire & Arran
ACUTE HOSPITALS NHS TRUST

Patient Profile

WRITE, IMPRINT OR ATTACH LABEL

Surname Galloway Hosp. No.
Forenames Stephen Sex
Address DoB 14/6/65
Ward or Dept.

Date of Admission Time
Type of Admission Emergency / Elective
From where
Age Religion
Marital Status

SUMMARY OF PRESENTING CONDITION

Next of Kin
Aware of Admission YES ☐ NO ☐
Name
Relationship
Address

Contact No.
Alterntive Next of Kin Name
Relationship
Address

Contact No

GP Consultant

PREVIOUS HEALTH PROBLEMS

MEDICATION USED AT HOME

DRUG	DOSAGE

ALLERGIES

Stored in ward YES ☐ No ☐ Date Sign
Returned to patient ☐ Relative ☐

RECORD OF INVESTIGATIONS PROCEDURES AND SURGERY

Date	Procedure/Surgery	Patient aware of result

ADMISSION ASSESSMENT

Home circumstances

Living alone	YES ☐	NO ☐	identfy carer(s)
Type of house			
Stairs at entrance	YES ☐	NO ☐	How many?
Toilet upstairs	YES ☐	NO ☐	
Bedroom upstairs	YES ☐	NO ☐	

COMMUNITY SERVICES

Home help	YES ☐	NO ☐	District Nurse	YES ☐	NO ☐
Meals on Wheels	YES ☐	NO ☐	Day Hospital	YES ☐	NO ☐
Sheltered house	YES ☐	NO ☐	Nursing Home	YES ☐	NO ☐
Visited by Specialist Nurse		YES ☐	NO ☐		

Which services informed of admission

DISCHARGE

Will personal transport be available for discharge YES ☐ NO ☐

Predicted discharge Complicated ☐ Uncomplicated ☐

PATIENTS PROPERTY

Property retained by patient:

I understand articles/valuables retained by me are my own responsibility.

Signature of patient or next of kin Date:

Property handed over for safe keeping:

Date taken to safe: Cash and valuables Ref. No.: Date returned:

OBSERVATION ON ADMISSION

Temperature	Pulse	BP	Respiration	O2 Saturation	Colour	LMP	BHCG	Glucostix

URINALYSIS	Midstream Urine sent for C+S	YES ☐ NO ☐	Date
Methicillen resistant staphyloccus aureus	YES ☐ NO ☐	Date	Result

Print Name	IN	Grade	Signature	Print Name	IN	Grade	Signature

IN - Initials DES - Designation SN - Staff Nurse EN - Enrolled Nurse STN - Student Nurse

A&E Num: 01029767
GALLOWAY STEPHEN
8 CARMEL DR
SPRINGSIDE
KA11 3AG
Male
14/06/1965
CHI Num:
PAS Num:

FAN1286
No.
/Dept.

NURSING NOTES

DATE	
	OD of 2 of Iora disinfectant and alcohol tt. Has apparently been drinking all day. Throat a bit red/swollen. Vomiting tt.
	BP 149/79 IV access - bloods ✓
	HR 90 chest Xray.
	R 14 c/o IVI N. Saline.
	SpO_2 98%
	Fluids to drink.
	Referred to ENT - advice wd SA.

DATE

AYRSHIRE AND ARRAN ACUTE HOSPITALS NHS TRUST

Version 2.0 Sept '97

Addressograph

Name Stephen Cattanach

Address

D.O.B. 16/6/65 Hosp No. Sex

Fluid and Low Risk Infusion Therapy Recording Chart

Ward/Dept .....

Consultant .....

INF I.D. 1	Date 2	Fluid (use block letters) Electrolyte additive 3	Vol(ml) mmols 4	Route of Admin. 5	Duration Rate 6	Pump Yes/No 7	Mon Time every(hrs/mins) 8	Signatures 9	Batch Nos. 10	Given by Added by 11	Start time 12
A	21/7/01	X1 Saline	1000	IV	2h				01E29A	Ubica	2015 hrs
B		(N) NaCl			4h			A			
C	21/7/01	5% dextrose			6h			A			
D		5% dextrose			6h			A			
E											
F											
G											
H											
I											
J											
K											
L											

Use this chart for infusions of Fluids, Electrolytes (less than [illegible] mmol per litre potassium chloride), B[illegible]l, [illegible]od Products and T.P.N.
If a volumetric pump is used the monitoring section on the reverse must be completed.

STA4015

If a volumetric pump is used for any infusion on the previous page, the infusion ID should be noted on the chart below and the monitoring details completed at intervals specified by the prescriber of the infusion.

The **INFUSION CHECKS** box should be ticked to indicate that the following checks have been made : **Pump Rate, Infusion site, Vol. remaining in bag is approx. as expected, patient's condition.**

INF I.D. 1	VOL. PUMP MAKE 2	SERIAL NUMBER 3	DATE 4	TIME 5	VOL. INFUSED (from pump) 6	INFUSION CHECKS 7	SIGNED 8

SHEET No. .....

MEDICINE PRESCRIPTION SHEET

KEY: O ORAL, IM INTRAMUSCULAR, IV INTRAVENOUS, SC SUBCUTANEOUS, SL SUBLINGUAL, ID INTRADERMAL, INH INHALATION, NEB NEBULISED, PR PER RECTUM, PV PER VAGINA, IT INTRATHECAL

Write, Imprint or attach label

Surname Galloway HCR No. .....

Forenames Stephen Sex .....

D.O.B. 11/6/65

Address .....

Ward/Dept. .....

KNOWN SENSITIVITY	
1.	2.

SUSPECTED ADVERSE REACTION	
MEDICINE	ADVERSE EFFECT
1.	
2.	

MEDICINES TO BE GIVEN REGULARLY (BLOCK CAPITALS)

PHARM.	Date Commenced	APPROVED NAME OF MEDICINE	DOSE	TIMES OF ADMINISTRATION: 6 am	8 am	10 am	12 md	2 pm	6 pm	8 pm	10 pm	12 mn	OTHER		ROUTE (see key)	OTHER INSTRUCTIONS	DOCTOR'S SIGNATURE	DISCONTINUED: DATE	INITIAL
	21/7/01	Paracetamol	1g			PRN	/	4/24							O				
	B 21/7/01	Dihydrocodeine	30mg			PRN	/	4/24							O				
	C																		
	D																		
	E																		
	F																		
	G																		
	H																		
	I																		
	J																		
	K																		
	L																		
	M																		
	N																		
	O																		
	P																		
	R																		
	S																		
	T																		
	V																		

STA 0235

MEDICINES TO BE GIVEN ONCE (BLOCK CAPITALS)

PHARM.	TO BE GIVEN		APPROVED NAME OF MEDICINE	DOSE	ROUTE (see key)	DOCTOR'S SIGNATURE	GIVEN BY	TIME GIVEN
	DATE	TIME						

NORTH AYRSHIRE AND ARRAN NHS TRUST
Hospital To Home Transfer Of Care Form

PATIENT DETAILS

Name STEPHEN GALLOWAY	Hosp No 468158
Addr 41 MAIN ROAD	GP NICOLL, WILLIAM
SPRINGSIDE	GP Practice GALSTON
	GP Phone 01563 820424
Phone NONE	CHI No
Key holder: Patient is key holder	

Key Holder Demographics And Notes

Name:	
Address:	
Phone No:	
Relationship:	

Admit Date 10/10/1999	Projected Discharge Date / /
Consultant DR JAAP	Actual Discharge Date / /
Named Nurse L FORREST	Mode of Transport TAXI
Ward 3E	

On discharge, patient plans to stay:	CHECKED BEFORE DISCHARGE Initials	Date
IN OWN HOME TO LIVE WITH WELL/INDEPENDENT ADULT	EM	11/10/1999

Patient Name: GALLOWAY, STEPHEN
Date Of Birth: 14/06/1965
Consultant: DR JAAP

Hosp. No: 468158
Ward: 3E
GP: NICOLL, WILLIAM

FINAL PATIENT AND CARER INFORMATION

Summary Diagnosis/Operation (as directed by consultant)
PT HAD ENDOSCOPY TODAY. S/B STAFF GRADE FIT FOR DISCHARGE.

P ient Informed/Understands Diagnosis	11/10/1999	MARSHALL, EMMA
Family Informed/Understands Diagnosis	11/10/1999	MARSHALL, EMMA
Confirmed Date of Discharge	11/10/1999	MARSHALL, EMMA
Hospital or Own Transport Arranged for (hrs)18:00	11/10/1999	MARSHALL, EMMA
Outpatient Appointment Arrangements DR JAAP CLINIC 6 WEEKS TIME		MARSHALL, EMMA

Medications on discharge:	Yes/No	Name
atient's own drugs returned	N	MARSHALL, EMMA
(tient able to administer own medication	Y	MARSHALL, EMMA
patient's medication will be supervised by another -	N	MARSHALL, EMMA
patient advised to contact GP regarding medication within 0 days 0 weeks of discharge	N	MARSHALL, EMMA

Patient Name: GALLOWAY, STEPHEN
Date Of Birth: 14/06/1965
Consultant: DR JAAP

Hosp. No: 468158
Ward: 3E
GP: NICOLL, WILLIAM

Health and social care services that have been notified of the discharge and advice on time of first contact.

Name of Service	Name of Service Provider	'Phone	Advised to see within ... (specify time or N/A)
			days of discharge
			days of discharge
			days of discharge
			days of discharge
			days of discharge
			days of discharge
			days of discharge

IMPORTANT PATIENT INFORMATION - IF YOU ARE AT ALL WORRIED OR FEEL THAT YOUR SYMPTOMS/CIRCUMSTANCES HAVE CHANGED, YOU SHOULD CONTACT YOUR GP OR RELEVANT SERVICE PROVIDER EARLIER.

Other relevant information: eg. investigations and results known and pending
There are no additional notes or comments

Completed By: _____

on ____/____/_____

Received By: _____

on ____/____/_____

Sent To:

Version 2.0 Sept '97

AYRSHIRE AND ARRAN ACUTE HOSPITALS NHS TRUST

Addressograph

Name ...STEPHEN GALLOWAY...
Address .....
.....
.....
D.O.B. .....Hosp No. ..... Sex .....

Fluid and Low Risk Infusion Therapy Recording Chart

Ward/Dept ...3E...

Consultant .....

INF I.D. 1	Date 2	Fluid (use block letters) Electrolyte additive 3	Vol(ml) mmols 4	Route of Admin. 5	Duration Rate 6	Pump Yes/No 7	Mon Time every(hrs/mins) 8	Signatures 9	Batch Nos. 10	Given by Added by 11	Start time 12
A	10/10/97	N Saline	500	IV	4hr	N		PMC	991208H	K. FOREST	00:40
B	10/10	N Saline 40 KCl	500 20mmol	IV	4hr			PMC	991008K	K. FOREST	05:00
C	10/10	5% Dex	500	IV	4hr			PMC			
D											
E											
F											
G											
H											
I											
J											
K											
L											

Use this chart for infusions of Fluids, Electrolytes (less than 40 mmol per litre potassium chloride), Blood, Blood Products and T.P.N.
If a volumetric pump is used the monitoring section on the reverse must be completed.

STA4015

Surname GALLOWAY Hosp. No. .....

Forenames STEVEN Sex M

..... D.O.B. .....

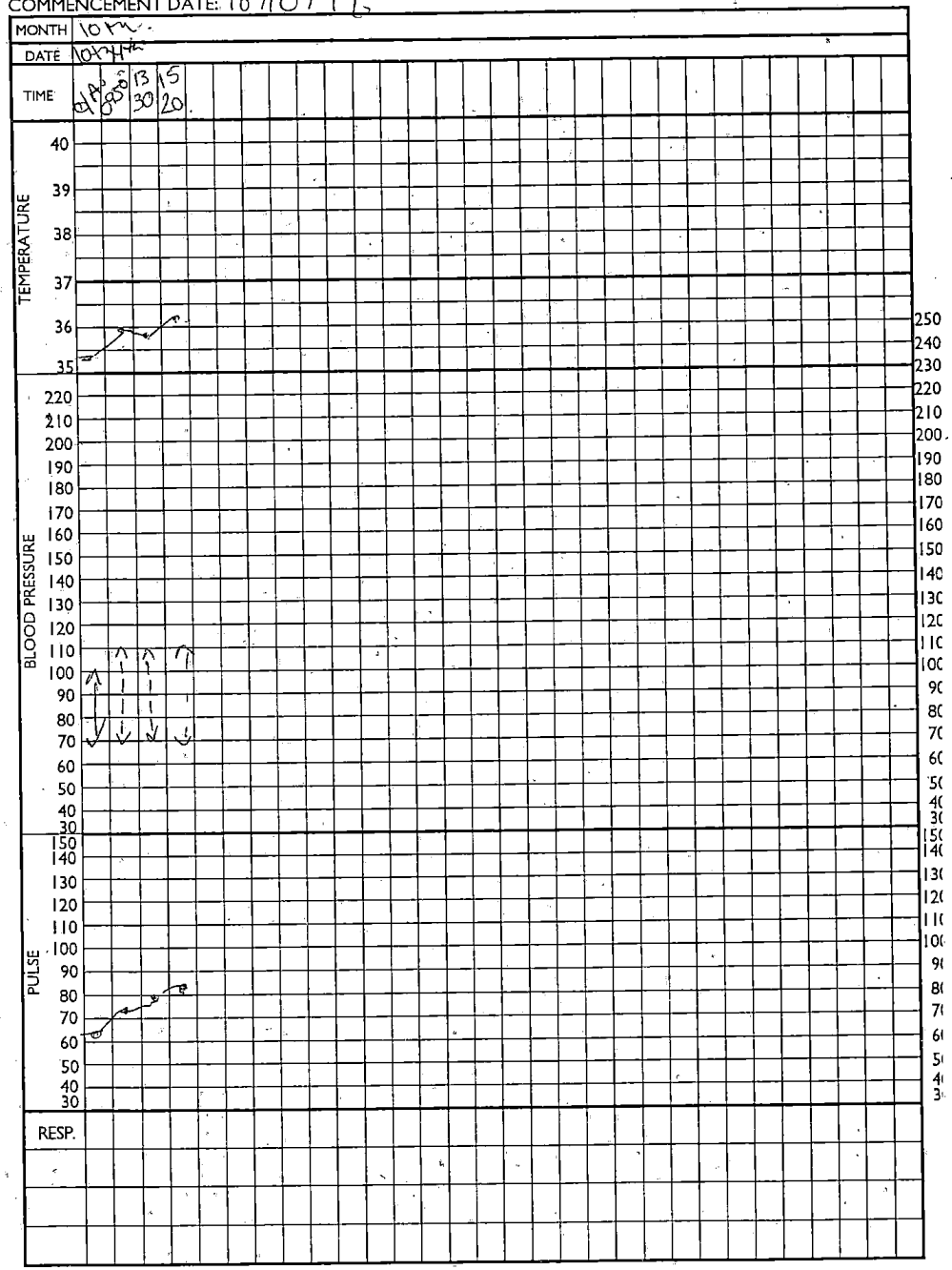
T.P.R & B.P. CHART

Address .....

.....

FAN0486 Ward/Dept. 3E

COMMENCEMENT DATE: 10/10/99



PATIENT ADMISSION RECORD - PATIENT RECORD DATA REPORT

CRN/Unit Number.....:468158
CHI Number.....: 0
Surname.....:GALLOWAY
Forename.....:STEPHEN
Maiden Name.....:
Date Of Birth...:14/06/1965
Age: (Years:034 Months:03 Days:27)
Sex.....:M Pref/Name:
Consultant:DR JAAP
Allergies: Food: N Drug: N Other: N

Address:41 MAIN ROAD
SPRINGSIDE

City...:
Postcode:KA11 3AN Phone:NONE

Pre Admission.:N Admit Type:.EME
Pre-Admit Date: / / Time:00:00
Pre-Admit Ward: Bed:
Pre-Assessment: Adm. Hx:N
Proj. Adm Date: / / Time:00:00
Admit Date....:10/10/1999 Time:23:17
Admit Ward....:3E Bed:000018
Prime Admit Dx:HAEMATEMESIS
Secondary Admission Diagnosis: GEN MEDI(
Pat. Type.....:GEN MEDICINE
Adm Type: .EME Patient On Pass:
Named Nurse..:L FORREST
Adm Nurse/Clrk..:DILLON, A
Is Patient MRSA ? N
Patient Category: NHS

Marital Status.:.SINGLE
Has This Patient Been An Inpatient Within The Last 12 Months: N
Language Spoken: Understands....:
Religion: PROTEST. Nationality....:BRITISH
Occupation:U/E Special Considerations:
From: HOME Source Of Referral: SELF REFER

ADMISSION DETAILS:

Temp: 35.4 Pulse: 62 Resp: 0 B.P.: 100/70 Hght: 0 '0 " Wgt: 0
Urinalysis..:
Operative Procedures: .....

Medications Prior To Admission:N Prior Med. Hx:Y
Patient Spoken To - Dr. Name: Date: / / Time: 00:00
Reason for Admission As Stated By Patient:
vomiting blood
Relative Notified Of Admission:
Relative/Friend Understanding Of Reason For Admission:

Relative Spoken To -
Relation:NO-ONE Dr/Nurse Name: Date: / / Time:00:00
Admit Ward...: 3E Current Ward.: 3E
Admit Bed....: 000018 Current Bed..: 000018
Property/ Valuables: .IN OWN POSSESSION
Clothing.....: RETAINED BY PATIENT
Hospital Info. Book Given.: Identification Band:
Projected Discharge Date: / / Discharge Code:
Clergy Visit.....: Research Patient Code: 0

NEXT OF KIN DETAILS:
Surname...: MCFARLANE Forename..: GEM
Relation..: partner
Address...: 41 MAIN ROAD
SPRINGSIDE

Postcode..:. KA11 3AN
Home Phone: NONE Work: Extension:

PATIENT ADMISSION RECORD - PATIENT RECORD DATA REPORT

PATIENT.....: GALLOWAY, STEPHEN
CURRENT WARD...: 3E
CURRENT BED....: 000018

EMERGENCY CONTACT DETAILS:
Surname...: MCFARLANE Forename..: GEM
Relation..: partner
Address...: 41 MAIN ROAD
SPRINGSIDE

Postcode..: KA11 3AN
Home Phone: NONE Work: Extension:

GENERAL PRACTITIONER DETAILS:
Surname...: NICOLL Forename: WILLIAM , S
Address...:
THE SURGERY
GALSTON
Postcode..: KA4 8JW

CONSULTANT/MR. 1 DETAILS:
Surname...: DR JAAP Forename:
Admit Clerk:

CONSULTANT/MR. 2 DETAILS:
Surname...: Forename:

ALLERGIES:
Food Allergies
None

Drug Allergies
None

Other Allergies
None

PATIENT ADMISSION RECORD - PATIENT RECORD DATA REPORT

PATIENT.....: GALLOWAY, STEPHEN
CURRENT WARD...: 3E
CURRENT BED....: 000018

Prior Medical History		
Date	Reason	Hospital / Physician
01/01/1901	?ULCER	

NOTE: Dates of 01/01/01 indicate actual date is unknown.
Dates of 01/01 and year indicate only the year was known.

NO PRIOR MEDICATION HISTORY ON FILE

ANY OTHER RELEVANT INFORMATION:

the preceding 12 months Y(N)

Are MRSA swabs required Y(N)

Date MRSA swabs sent / /

Signature

Surnan XH 468158 468158

Forena GALLOWAY STEPHEN

41 MAIN ROAD

SPRINGSIDE

KA11 3AN 65

Addr DR.W NICOLL 14/06/1965

5A HENRIETTA ST

GALSTON

CHI

FAN0986 3E

NURSING ASSESSMENT

3415

Date of admission: 10/10/99 Time: 1115

Type of admission: emergency

Accompanied by: SIN + PORTER

From where: Home

PATIENT'S OCCUPATION: unemployed

MARITAL STATUS: single

Dependants - children Ages:

- others NONE

Living alone?

(1) (NO) with whom? with Partner

(2) YES - any supportive help? MOST OF TIME

RELIGION: C of S

Seen by Minister/Priest

NEXT OF KIN: Gem mcfarlane

Partner

Relationship: as above

Address:

Home phone no.: NONE

Work phone no.:

ALTERNATIVE NEXT OF KIN:

Relationship:

Address:

Phone no.:

REASON FOR THIS ADMISSION

Haematemesis

PATIENT'S ACCOUNT OF ILLNESS

1 episode of haematemesis fresh blood yesterday - tonight one episode dark/ in nature and clots evident. Self referral to A&E -> 3E

SPECIAL VISITING NEEDS

N/A

PREVIOUS HEALTH PROBLEMS

? previous ulcer

SPECIAL NEEDS AT HOME

- housing
- social N/A
- other

DRUGS USED BEFORE ADMISSION

NONE

ALLERGIES

NIL KNOWN

TAKEN FOR SAFEKEEPING RETURNED

Property checked (YES) NO

Valuables in hospital safe YES (NO)

NURSING ASSESSMENT

1. **Capable of self care** (YES) / NO

2. **Communicating**
   Vision - any problems? YES
   - spectacles? All the time Specs in house
   - contact lenses?
   Hearing - any problems? None
   - hearing aid?
   - battery type?
   Speech difficulty YES / (NO)

3. **Mobility** - independent? YES
   - with assistance?
   - remarks.

4. **Eating and drinking**
   - appetite? Poor eater normally
   - special diet?
   - dislikes?
   - assistance needed YES / (NO)

5. **Personal cleaning and dressing**
   - independent? YES
   - with assistance?
   - remarks.

6. **Bladder and Bowels** - any problems? None
   - special needs?

7. **Sleeping** - pattern Approx 3hrs/night.
   - what helps?

8. **Recreational interests**

9. **Other relevant information**
Smoker - 30 C.P.D.
Alcohol - 1 can beer yesterday
Drinking a lot approx 1 month ago.

GENERAL APPEARANCE/CONDITION
appears well.

GENERAL OBSERVATIONS
T 36.4c P 62 R B/P 100/70
Height: Weight: Norton score:
Urine:
SKIN INSPECTION
ORAL INSPECTION
Condition of mouth:
Condition of teeth:
Dentures: Upper Lower Partial
Crown:
Any problems?

DISCHARGE/FUTURE PLANS	Date ordered	Date given	Sign
Education of condition/ limitations/ rehabilitation (a) Patient			
(b) Relatives			
Discharge medications			
Warfarin Steroid/ Tetanus card			
Transport home			
Out-patient appointment			
Walking stick/crutches			
Dressings:			
Other:			
Community nursing			
Home help			
Meals on wheels			
Social worker			
Physiotherapy			
Occupational Therapy			
Speech Therapy			
Geriatric waiting list			
Sheltered housing			
Other:			

FAN1286

XH 468158

Sur GALLOWAY STEPHEN
For 41 MAIN ROAD
SPRINGSIDE
KA11 3AN
14/06/1965
Ad DR.W NICOLL
5A HENRIETTA ST
GALSTON
CHI
Ward/Dept.

NURSING NOTES

DATE	
11/10/99	Emergency Admission from A/E via self referral following 2 episodes of ? haematemesis over past two days. IV. access gained and bloods taken in A/E. CXR done. Vital signs satisfactory. Medics aware of admission. SN FORREST
	Seen by Dr Hume ? gastritis. Commence I.V. fluids 4hrly. Remain nil by mouth meantime. For Endoscopy morning. Commenced 30ton stat dose given. SN FORREST
	Late to settle slept well. SN FORREST
	mobilising independantly to smoke room.
10[45]	Endoscopy unit S.O$_2$ 94%. P80 SN FORREST
	O$_2$ 2 Litres commenced via nasal cannula Xylocaine throat spray applied. Gastric endoscopy carried out. Adeat obtained KL A
11.10	Recovery - BP 117/76. P 77 SaO 97%
11.25.	BP 116/68 P 73
	May return to ward GM
	Gastric ulcer evident
1130	Patient returned to ward. Tolerated sip of water followed by tea. KL
1300	Soup & sandwiches tolerated.

DATE	
16[00]	s/B Dr Lagan for discharge home, discharge letter, hospital taxi. Venflon not insitu. EMarshall 6 week appt appointment arranged. EMarshall

NAME

DATE	INVESTIGATION	DATE	INVESTIGATION
	SERIAL ECGS 1 2 3 4 5 6		ECHOCARDIOGRAM
			T.O.E.
	CXR		ETT
	URINALYSIS		
	FASTING LIPIDS	----------	------- DISCHARGE INVESTIGATIONS----
		E.T.T.	Y / N ARRANGED / DR
		M.O.P.	Y / N ARRANGED / S/N
		A. COAG	Y / N ARRANGED / DR

RESULTS

DATE	10/10/99							
ESR								
UREA 2.5 - 7.5	6.1							
CREATININE 50 -125	130							
SODIUM 135 - 145	147							
POTASSIUM 3.5 - 5.0	3.3							
CHLORIDE 95 - 108	103							
BICARB. 22 - 33.	19							
GLUCOSE 4 - 5.5	5.4							
CRP								
AST. 10 - 40								
ALT 10 - 50								
CK 24 - 170(F)195(M)								
LDH 250 - 540								
TRIG 0.84 - 1.94								
CHOLEST. 3.1 - 6.5								
DIGOXIN								
HB 10-12(F) 12-14(M)	14.5							
WCC 4 - 11	12.2							
PLATELETS(180-360	209							
INR 1 - 4								
APPT 2- 2.5 x CONT.	25							
CONTROL	26							
FIBRINOGEN	243							
PROTHROMBIN	13							
CONTROL	14							
THROMBIN								
CONTROL								
PH 7.35 - 7.45								
pO2 80 - 100								
pCO2 35 - 45								
HCO3 22 - 33								

XH 468158

GALLOWAY STEPHEN
41 MAIN ROAD
SPRINGSIDE
KA11 3AN

14/06/1965

DR.W NICOLL
5A HENRIETTA ST
GALSTON
CHI

GROUP MEDICAL DIRECTORATE INVESTIGATIONS CHART

BLOODS							
FBC/PCV							
U&E'S							
GLUCOSE							
GLUCOSE PROFILE							
X-MATCH							
COAG SCREEN							
BLOOD-CULTURES							
CARDIAC ENZYMES							
GASES							
OTHER							
LEVELS							
PARACETAMOL							
SALICYLATE							
ALCOHOL							
GENTAMYCIN							
VANCOMYCIN							
PHENYTOIN							
OTHER							
BIOPSY							
LUNG AND TAP							
LIVER							
PARACENTESIS							
SKIN							
OTHER							
XRAY							
CXRAY							
U/S							
12 LEAD ECG							
CT SCAN							
CAROTID DOPPLER							
OTHER							
ENDOSCOPY							
BRONCHOSCOPY							
SPIROMETRY							
BARIUMMEAL							
BARIUM ENEMA							
SIGMOIDOSCOPY							
OTHER							
SPUTUM CULTURE							
SPUTUM OTHER							
HEAF TEST							
FAECES							
URINE C&S							
URINE OTHER							
SWABS							
MRSA							
OTHER							

MEDICINES TO BE GIVEN ONCE (BLOCK CAPITALS)

PHARM.	TO BE GIVEN DATE	TO BE GIVEN TIME	APPROVED NAME OF MEDICINE	DOSE	ROUTE (see key)	DOCTOR'S SIGNATURE	GIVEN BY	TIME GIVEN
	10/10/99	2345	LANSOPRAZOLE	30mg	O	P M	L Follest	00:30

SHEET No. .....

MEDICINE PRESCRIPTION SHEET

KEY: O ORAL; IM INTRAMUSCULAR; IV INTRAVENOUS; SC SUBCUTANEOUS; SL SUBLINGUAL; ID INTRADERMAL; INH INHALATION; NEB NEBULISED; PR PER RECTUM; PV PER VAGINA; IT INTRATHECAL

Write XH 468158
Surna GALLOWAY STEPHEN
Foren. 41 MAIN ROAD
SPRINGSIDE
KA11 3AN
Addre 14/06/1965
IR.W NICOLL
5A HENRIETTA ST
GALSTON
CHI

KNOWN SENSITIVITY	
1.	2.

SUSPECTED ADVERSE REACTION	
MEDICINE	ADVERSE EFFECT
1.	
2.	

MEDICINES TO BE GIVEN REGULARLY (BLOCK CAPITALS) Code STA0235

PHARM.	Date Commenced	APPROVED NAME OF MEDICINE	DOSE	TIMES OF ADMINISTRATION									OTHER		ROUTE (see key)	OTHER INSTRUCTIONS	DOCTOR'S SIGNATURE	DISCONTINUED	
				6 am	8 am	10 am	12 md	2 pm	6 pm	8 pm	10 pm	12 mn						DATE	INITIAL
[illegible]	A 10/10/98	LANSOPRAZOLE	30mg		✓										O		DM		
	B																		
	C																		
	D																		
	E																		
	F																		
	G																		
	H																		
	I																		
	J																		
	K																		
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	S																		
	T																		
	V																		

XH 468158

SHEET

GALLOWAY STEPHEN
41 MAIN ROAD
SPRINGSIDE
KA11 3AN

14/06/1965

DR.W NICOLL
5A HENRIETTA ST
GALSTON
CHI

MEDICINE RECORDING SHEET

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record A

If patient absent record A If medicine not available record A

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
10/10/99		A								
	Init.	LWF								
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

SHEET No .....

MEDICINE RECORDING SHEET

Name .....

Age .....

Consultant .....

Hospital .....

Enter code in box and initial when medicine is taken.

If medicine refused record (A) If patient unable to swallow record A

If patient absent record A If medicine not available record A

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

Date	6a.m.	8a.m.	10a.m.	12m.d.	2p.m.	6p.m.	8p.m.	10p.m.	12m.n.	Other Administrations
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									
	Init.									

Inpatient prescription & administration record for GALLOWAY, Stephen (CHI: 1406650854).

NHS Ayrshire & Arran
02:02
12/06/24

Patient Demographics

GALLOWAY, Stephen (CHI: 1406650854)
DOB: 14/06/1965
28 Redburn Place, Irvine,
Ayrshire,
KA12 9BH

GP details
Miller, Dr. Tg,
9 Frew Terrace,
Irvine,
KA12 9DY

Admitted: 10/06/2024 23:10:00
Discharged: 11/06/2024

Transfer history
Admission 2024-06-10 2 XCAU PRE ADMIT

Responsible Consultant history
Dr Natalie Rennie 10/06/24 23:10

Current recorded allergy (reaction): NKDA

Regular Medication Orders

AMITRIPTYLINE 25 mg Tablets
☒ 11/06/24 22:00 25 mg ONCE daily at 10pm (Oral) DR GORDON MCKINNON

AMOXICILLIN_1 g Injection
☒ 11/06/24 13:00 1 g THREE times daily - 7am;1pm;10pm (Intravenous Slow Bolus Injection) DR GORDON MCKINNON
11/06/24 13:00 Not Charted prior to Discharge SYSTEM

LANSOPRAZOLE 30 mg Capsules
☒ 12/06/24 07:00 30 mg ONCE daily at 7am (Oral) DR GORDON MCKINNON

PABRINEX High Potency Intravenous Injection
☒ 11/06/24 13:00 2 x 2 Ampoules THREE times daily - 7am;1pm;10pm (Intravenous Intermittent Infusion) DR GORDON MCKINNON
11/06/24 13:00 Not Charted prior to Discharge SYSTEM

TIOTROPIUM 2.5 micrograms (SPIRIVA) Respimat
☒ 12/06/24 07:00 5 microgram ONCE daily at 7am (Inhalation) DR GORDON MCKINNON

As Required Medication Orders

DIAZEPAM - GMAWs REGIMEN - AS CHARTED as required
☒ 11/06/24 09:55 1 Dose (Oral) AS PER GMAWS CHART DR GORDON MCKINNON

SALBUTAMOL 100 micrograms (MDI) per metered dose as required
☒ 11/06/24 09:54 200 microgram (Inhalation) FOR BREATHLESSNESS DR GORDON MCKINNON

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Inpatient prescription & administration record for GALLOWAY, Stephen (CHI: 1406650854).

NHS Ayrshire & Arran
02:01
20/10/23

Patient Demographics

GALLOWAY, Stephen (CHI: 1406650854)
DOB: 14/06/1965
28 Redburn Place, Irvine,
Ayrshire,
KA12 9BH

Admitted: 12/10/2023 22:21
Discharged: 19/10/2023

Transfer history

Admission	2023-10-12	XCAU PRE ADMIT
Transfer	2023-10-14	XCAU INPATIENT
Transfer	2023-10-14	WARD 3D - XH

GP details

Miller, Dr. Tg,
9 Frew Terrace,
Irvine,
KA12 9DY

Responsible Consultant history

Dr Gordon Maxwell	12/10/23	22:21
Dr Katrina Weir	14/10/23	12:25
Dr Enes Muazzen	14/10/23	17:20

Current recorded allergy (reaction): NKDA

Regular Medication Orders

PABRINEX High Potency Intravenous Injection

14/10/23 07:00 — 1 x 2 Ampoules ONCE daily at 7am (Intravenous Intermittent Infusion) — DR LAUREN ARNOLD

14/10/23	07:00	14/10/2023	07:53	NURSE MARGARET GORDON
15/10/23	07:00	15/10/2023	07:35	NURSE JODIE POLLOCK
16/10/23	07:00	IV Access Unavailable		NURSE MEGAN BELL

Discontinued on: 16/10/2023 10:02 by: DR RACHAEL ELLIS . Reason: Course Complete

SANDO-K 12 mmol Effervescent Tablets

13/10/23 13:00 — 24 mmol THREE times daily - 7am;1pm;10pm (Oral) for 2 day(s) — DR PHILIP HODKINSON

13/10/23	13:00	13/10/2023	12:53	NURSE MARIANNA PATERSON
13/10/23	22:00	13/10/2023	23:14	NURSE JENNA MCCLURE
14/10/23	07:00	Unavailable Medicine		NURSE MARGARET GORDON
14/10/23	13:00	14/10/2023	12:53	NURSE REBECCA PATRICK
14/10/23	22:00	14/10/2023	23:27	NURSE JODIE POLLOCK
15/10/23	07:00	15/10/2023	09:36	NURSE NAOMI NELSON

16/10/23 13:00 — 36 mmol THREE times daily - 7am;1pm;10pm (Oral) — DR RACHAEL ELLIS

16/10/23	13:00	16/10/2023	13:08	NURSE MEGAN BELL
16/10/23	22:00	16/10/2023	21:58	NURSE ALEXANDRA KELLY
17/10/23	07:00	Discharged Patient		NURSE NICOLA LENNOX
17/10/23	13:00	Discharged Patient		NURSE NICOLA LENNOX
17/10/23	22:00	Discharged Patient		NURSE NICOLA LENNOX
18/10/23	07:00	Discharged Patient		NURSE NICOLA LENNOX
18/10/23	13:00	Discharged Patient		NURSE NICOLA LENNOX
18/10/23	22:00	Discharged Patient		NURSE NICOLA LENNOX
19/10/23	07:00	Not Charted prior to Discharge		MR GARY CAMPBELL

16/10/23 10:06 — 36 mmol (Oral) — DR RACHAEL ELLIS

16/10/23	10:06	Withheld	NURSE MEGAN BELL

THIAMINE 100 mg Tablets

13/10/23 13:00 — 100 mg THREE times daily - 7am;1pm;10pm (Oral) — DR PHILIP HODKINSON

13/10/23	13:00	13/10/2023	12:52	NURSE MARIANNA PATERSON
13/10/23	22:00	13/10/2023	23:14	NURSE JENNA MCCLURE
14/10/23	07:00	14/10/2023	07:53	NURSE MARGARET GORDON
14/10/23	13:00	14/10/2023	12:53	NURSE REBECCA PATRICK
14/10/23	22:00	14/10/2023	23:28	NURSE JODIE POLLOCK
15/10/23	07:00	15/10/2023	09:36	NURSE NAOMI NELSON
15/10/23	13:00	15/10/2023	14:03	NURSE NAOMI NELSON
15/10/23	22:00	15/10/2023	22:51	NURSE JODIE POLLOCK
16/10/23	07:00	16/10/2023	08:52	NURSE MEGAN BELL
16/10/23	13:00	16/10/2023	13:08	NURSE MEGAN BELL
16/10/23	22:00	16/10/2023	21:58	NURSE ALEXANDRA KELLY
17/10/23	07:00	Discharged Patient		NURSE NICOLA LENNOX
17/10/23	13:00	Discharged Patient		NURSE NICOLA LENNOX
17/10/23	22:00	Discharged Patient		NURSE NICOLA LENNOX
18/10/23	07:00	Discharged Patient		NURSE NICOLA LENNOX
18/10/23	13:00	Discharged Patient		NURSE NICOLA LENNOX
18/10/23	22:00	Discharged Patient		NURSE NICOLA LENNOX

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THIAMINE 100 mg Tablets *(Continued)*

19/10/23	07:00	Not Charted prior to Discharge	MR GARY CAMPBELL

TIOTROPIUM 2.5 micrograms (SPIRIVA) Respimat

☒ 14/10/23 07:00 5 microgram ONCE daily at 7am (Inhalation) MISS JADE KIRKPATRICK (PIP)

14/10/23	07:00	Unavailable Medicine	NURSE MARGARET GORDON
15/10/23	07:00	Unavailable Medicine	NURSE NAOMI NELSON
16/10/23	07:00	Unavailable Medicine	NURSE MEGAN BELL
17/10/23	07:00	Discharged Patient	NURSE NICOLA LENNOX
18/10/23	07:00	Discharged Patient	NURSE NICOLA LENNOX
19/10/23	07:00	Not Charted prior to Discharge	MR GARY CAMPBELL

As Required Medication Orders

CO-CODAMOL 15/500 Tablets as required

☒ 13/10/23 08:36 2 Tablet FOUR times daily - 7am;1pm;6pm;10pm (Oral) FOR PAIN DR MICHAEL DEIGHAN

Ⓞ Discontinued on: 13/10/2023 12:18 by: MISS JADE KIRKPATRICK (PIP) . Reason: Discontinued due to conflict

CODEINE PHOSPHATE 15 mg Tablets as required

☒ 13/10/23 12:18 30 mg FOUR times daily - 7am;1pm;6pm;10pm (Oral) pain MISS JADE KIRKPATRICK (PIP)

DIAZEPAM - GMAWs REGIMEN - AS CHARTED as required

☒ 13/10/23 08:35 1 Dose (Oral) AS PER GMAWS CHART REFER TO GMAWS CHART DR MICHAEL DEIGHAN

Ⓞ Discontinued on: 13/10/2023 10:49 by: DR PHILIP HODKINSON . Reason: Course Complete

13/10/23 12:40 1 Dose (Oral) AS PER GMAWS CHART DR LAUREN ARNOLD

1.00 Dose	13/10/2023	12:45	NURSE MARIANNA PATERSON/ NURSE HEATHER MORTON
1.00 Dose	14/10/2023	18:17	NURSE HANNAH LYNCH
1.00 Dose	14/10/2023	21:25	NURSE JODIE POLLOCK
1.00 Dose	15/10/2023	02:38	NURSE ERIN MURPHY
1.00 Dose	15/10/2023	06:54	NURSE JODIE POLLOCK
1.00 Dose	15/10/2023	09:37	NURSE NAOMI NELSON
1.00 Dose	15/10/2023	14:03	NURSE NAOMI NELSON

PARACETAMOL 500 mg Tablets as required

☒ 13/10/23 12:18 1,000 mg FOUR times daily - 7am;1pm;6pm;10pm (Oral) FOR PAIN MISS JADE KIRKPATRICK (PIP)

SALBUTAMOL 100 micrograms (MDI) per metered dose as required

☒ 13/10/23 12:22 200 microgram (Inhalation) FOR BREATHLESSNESS MISS JADE KIRKPATRICK (PIP)

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Patient level notes

Note to Pharmacist added by **MISS NATALIE COLE** on 16/10/2023 at 15:46
Title: TIOTROPIUM 2.5
Supplied and labelled ward 3D 16/10/23 NC

Note to Pharmacist added by **MISS JADE KIRKPATRICK (PIP)** on 13/10/2023 at 12:15
Title: ED REVIEW
PC - alc intoxicated, chest pain MSK? fall, low K
PMH - COPD; alc dependence
DHx - ECS JK 13/10

Issues:
1) VTEp - dalt 5000

2) k 2.9 - given IV now switched to po
Na 127 - wh TCA and PPI for now JK 13/10

3) alc withdrawal? not scoring - gmaws stopped JK 13/10

4) analgesia - switched cocodamol 15/500 to separate formulations JK 13/10

Protocol Information added by **MR RICHARD COTTRELL (PIP)** on 13/10/2023 at 08:35
Title: Prescribing Guidance

The ADTC 301 (1) Ayrshire Assessment and Monitoring of Alcohol Withdrawal Syndrome (AAMAWS) guideline can be found on AthenA by clicking the link below.

<http://athena/adtc/DTC%20%20Clinical%20Guidelines/ADTC301.pdf>

Guidance on the prescribing of the AAMAWS treatment protocols on HEPMA can be found here:

http://athena/pharmacy/HEPMA/Documents/AAMAWs%20-%20Prescriber%20Guidance.docx

Please ensure you complete and sign the protocol when prescribing.

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Inpatient prescription & administration record for GALLOWAY, Stephen (CHI: 1406650854).

NHS Ayrshire & Arran
02:01
18/10/23

Patient Demographics

GALLOWAY, Stephen (CHI: 1406650854)
DOB: 14/06/1965
28 Redburn Place, Irvine,
Ayrshire,
KA12 9BH

GP details
Miller, Dr. Tg,
9 Frew Terrace,
Irvine,
KA12 9DY

Admitted: 12/10/2023 22:21
Discharged: 17/10/2023

Transfer history

Admission	2023-10-12	XCAU PRE ADMIT
Transfer	2023-10-14	XCAU INPATIENT
Transfer	2023-10-14	WARD 3D - XH

Responsible Consultant history

Dr Gordon Maxwell	12/10/23	22:21
Dr Katrina Weir	14/10/23	12:25
Dr Enes Muazzen	14/10/23	17:20

Current recorded allergy (reaction): NKDA

Regular Medication Orders

PABRINEX High Potency Intravenous Injection

14/10/23 07:00 1 x 2 Ampoules ONCE daily at 7am (Intravenous Intermittent Infusion) — DR LAUREN ARNOLD

14/10/23	07:00	14/10/2023	07:53	NURSE MARGARET GORDON
15/10/23	07:00	15/10/2023	07:35	NURSE JODIE POLLOCK
16/10/23	07:00	IV Access Unavailable		NURSE MEGAN BELL

Discontinued on: 16/10/2023 10:02 by: DR RACHAEL ELLIS . Reason: Course Complete

SANDO-K 12 mmol Effervescent Tablets

13/10/23 13:00 24 mmol THREE times daily - 7am;1pm;10pm (Oral) for 2 day(s) — DR PHILIP HODKINSON

13/10/23	13:00	13/10/2023	12:53	NURSE MARIANNA PATERSON
13/10/23	22:00	13/10/2023	23:14	NURSE JENNA MCCLURE
14/10/23	07:00	Unavailable Medicine		NURSE MARGARET GORDON
14/10/23	13:00	14/10/2023	12:53	NURSE REBECCA PATRICK
14/10/23	22:00	14/10/2023	23:27	NURSE JODIE POLLOCK
15/10/23	07:00	15/10/2023	09:36	NURSE NAOMI NELSON

16/10/23 13:00 36 mmol THREE times daily - 7am;1pm;10pm (Oral) — DR RACHAEL ELLIS

16/10/23	13:00	16/10/2023	13:08	NURSE MEGAN BELL
16/10/23	22:00	16/10/2023	21:58	NURSE ALEXANDRA KELLY
17/10/23	07:00	Not Charted prior to Discharge		SYSTEM
17/10/23	13:00	Not Charted prior to Discharge		SYSTEM

16/10/23 10:06 36 mmol (Oral) — DR RACHAEL ELLIS

16/10/23	10:06	Withheld		NURSE MEGAN BELL

THIAMINE 100 mg Tablets

13/10/23 13:00 100 mg THREE times daily - 7am;1pm;10pm (Oral) — DR PHILIP HODKINSON

13/10/23	13:00	13/10/2023	12:52	NURSE MARIANNA PATERSON
13/10/23	22:00	13/10/2023	23:14	NURSE JENNA MCCLURE
14/10/23	07:00	14/10/2023	07:53	NURSE MARGARET GORDON
14/10/23	13:00	14/10/2023	12:53	NURSE REBECCA PATRICK
14/10/23	22:00	14/10/2023	23:28	NURSE JODIE POLLOCK
15/10/23	07:00	15/10/2023	09:36	NURSE NAOMI NELSON
15/10/23	13:00	15/10/2023	14:03	NURSE NAOMI NELSON
15/10/23	22:00	15/10/2023	22:51	NURSE JODIE POLLOCK
16/10/23	07:00	16/10/2023	08:52	NURSE MEGAN BELL
16/10/23	13:00	16/10/2023	13:08	NURSE MEGAN BELL
16/10/23	22:00	16/10/2023	21:58	NURSE ALEXANDRA KELLY
17/10/23	07:00	Not Charted prior to Discharge		SYSTEM
17/10/23	13:00	Not Charted prior to Discharge		SYSTEM

TIOTROPIUM 2.5 micrograms (SPIRIVA) Respimat

14/10/23 07:00 5 microgram ONCE daily at 7am (Inhalation) — MISS JADE KIRKPATRICK (PIP)

14/10/23	07:00	Unavailable Medicine		NURSE MARGARET GORDON
15/10/23	07:00	Unavailable Medicine		NURSE NAOMI NELSON
16/10/23	07:00	Unavailable Medicine		NURSE MEGAN BELL
17/10/23	07:00	Not Charted prior to Discharge		SYSTEM

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As Required Medication Orders

CO-CODAMOL 15/500 Tablets as required

☒ 13/10/23 08:36 2 Tablet FOUR times daily - 7am;1pm;6pm;10pm (Oral) FOR PAIN DR MICHAEL DEIGHAN

⓪ Discontinued on: 13/10/2023 12:18 by: MISS JADE KIRKPATRICK (PIP) . Reason: Discontinued due to conflict

DIAZEPAM - GMAWs REGIMEN - AS CHARTED as required

☒ 13/10/23 08:35 1 Dose (Oral) AS PER GMAWS CHART REFER TO GMAWS CHART DR MICHAEL DEIGHAN

⓪ Discontinued on: 13/10/2023 10:49 by: DR PHILIP HODKINSON . Reason: Course Complete

☒ 13/10/23 12:40 1 Dose (Oral) AS PER GMAWS CHART DR LAUREN ARNOLD

1.00 Dose	13/10/2023	12:45	NURSE MARIANNA PATERSON/ NURSE HEATHER MORTON
1.00 Dose	14/10/2023	18:17	NURSE HANNAH LYNCH
1.00 Dose	14/10/2023	21:25	NURSE JODIE POLLOCK
1.00 Dose	15/10/2023	02:38	NURSE ERIN MURPHY
1.00 Dose	15/10/2023	06:54	NURSE JODIE POLLOCK
1.00 Dose	15/10/2023	09:37	NURSE NAOMI NELSON
1.00 Dose	15/10/2023	14:03	NURSE NAOMI NELSON

Patient level notes

Note to Pharmacist added by **MISS NATALIE COLE** on 16/10/2023 at 15:46

Title: TIOTROPIUM 2.5

Supplied and labelled ward 3D 16/10/23 NC

Note to Pharmacist added by **MISS JADE KIRKPATRICK (PIP)** on 13/10/2023 at 12:15

Title: ED REVIEW

PC - alc intoxicated, chest pain MSK? fall, low K
PMH - COPD; alc dependence
DHx - ECS JK 13/10

Issues:
1) VTEp - dalt 5000

2) k 2.9 - given IV now switched to po
Na 127 - wh TCA and PPI for now JK 13/10

3) alc withdrawal? not scoring - gmaws stopped JK 13/10

4) analgesia - switched cocodamol 15/500 to separate formulations JK 13/10

Protocol Information added by **MR RICHARD COTTRELL (PIP)** on 13/10/2023 at 08:35

Title: Prescribing Guidance

The ADTC 301 (1) Ayrshire Assessment and Monitoring of Alcohol Withdrawal Syndrome (AAMAWS) guideline can be found on AthenA by clicking the link below.

<http://athena/adtc/DTC%20%20Clinical%20Guidelines/ADTC301.pdf>

Guidance on the prescribing of the AAMAWS treatment protocols on HEPMA can be found here:

http://athena/pharmacy/HEPMA/Documents/AAMAWs%20-%20Prescriber%20Guidance.docx

Please ensure you complete and sign the protocol when prescribing.

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